A CLINICAL MENTORING FRAMEWORK FOR STUDENT NURSES IN MAURITIUS

by

DHUNRAJ FOOLCHAND

submitted in accordance with the requirements

for the degree of

Doctor in Philosophy – Nursing

in the subject

Health Studies

at the

UNIVERSITY OF SOUTH AFRICA

PROMOTER: PROFESSOR JEANETTE MARITZ

JANUARY 2020

DECLARATION

Name : DHUNRAJ FOOLCHAND
Student number : 36763365
Degree : Doctor in Philosophy – Nursing

A clinical mentoring framework for student nurses in Mauritius

I declare that this thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the thesis to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

SIGNATURE

2/6/20

DATE

DEDICATION

“I dedicate this study to my mother Heerawtee Foolchand, my wife Soojata, my daughters; Hansha, Ashna, Rya, Sambhavna and my nephew Pushan”

AND

In loving memory of my father Poorun Foolchand, my lovely uncle Jeeunpersad and brother Anil.

ACKNOWLEDGEMENTS

I would like to express my sincere thanks to the following people who have contributed to the completion of this thesis:

- My Promotor Prof Jeanette Maritz for her most significant input, her unconditional support, constant motivation, insight, guidance, and above all, her positive attitude throughout the conduct of this study.

- Dr Gopee, Director of Health Services, for permission to conduct the study in the regional hospitals throughout the island.

- My wife Soojata for her encouragement, patience and loving support when I needed it most.

- The presence of my daughters, Ashna, Rhia, Sambhavna and my nephew Pooshan for maintaining a healthy balance between work, social obligations and study.

- Professor Jeewan from the University of Mauritius for statistical assistance and providing access to printed articles.

- My friend Suren Reesaul for his help in managing data analysis.

- My friend Devina Putty for her patience and courage during the data collection.

- My friend Veena for patiently formatting the manuscript.

- The participants for their willingness, time and input.

Lastly, I would wish to thank all those who have contributed in one way or another to make my task easy.

A CLINICAL MENTORING FRAMEWORK FOR STUDENT NURSES IN MAURITIUS

STUDENT NUMBER: 3676-336-5
STUDENT: DHUNRAJ FOOLCHAND
DEGREE: DOCTOR IN PHILOSOPHY IN NURSING
DEPARTMENT: HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA
PROMOTER: PROF JEANETTE MARITZ

ABSTRACT

One of the major challenges associated with nursing education in this 21st century is the practice preparation of student nurses in this complex healthcare environment to ensure their fitness to practice. Practice training relies largely on mentoring which is central to the professional development of student nurses. In the local context of Mauritius, the clinical mentoring of students is service-led rather than education-driven. In the context of the current debate, it is becoming evident that the clinical mentoring system in Mauritius needs rethinking in order to respond to the emerging training and education needs of nurses.

The aim of the study was to develop a contextually relevant clinical mentoring framework for student nurses in Mauritius in order to enhance the standard of student nurses' training during clinical placements.

A descriptive exploratory sequential mixed method with a cross-sectional design was used in this study. The sample for the qualitative phase consisted of eight nurses, while there were 255 nurses and 115 students in the quantitative phase. Data were collected through face-to-face semi-structured interviews and a self-administered questionnaire, respectively. The findings were synthesised using Dickoff et al's (1968) survey list to develop the clinical mentoring framework for student nurses.

The findings of the qualitative phase indicated that the current learning support system for students in the clinical settings did not reflect what mentoring should be about. Mentoring *per se* was not practiced, but rather a form of clinical accompaniment resulting in the practice being less effective for its purpose. A variety of activities/roles were described that nurses fulfil in everyday clinical practice that included some aspects of a mentoring approach. Participants provided a number of pre-requisites needed for the mentoring process.

The results of the quantitative phase revealed that both students and nurses recognised that the mentoring system was informal. They also shared the same views regarding barriers to mentoring, such as staff shortage, lack of resources, and inadequate support from management and the Central School of Nursing (CSN). Along with mentoring competencies, teaching, assessing, communication, managerial and leadership skills, were identified as core competencies for mentors.

Effective clinical mentoring requires an understanding of the mentoring process from a broader perspective. Mentors should be equipped with core competencies. Successful mentoring outcomes are dependent on a conducive clinical learning environment (CLE) and the approach used to mentor. The framework on mentoring could guide and provide a holistic approach to mentoring students in CLEs. However, emphasis must be placed on the collaboration between the management, the clinical setting and the CSN. The clinical framework developed from this study can be tested for its effectiveness.

Keywords*: *Mentoring, Clinical Learning Environment, Standards, Learning Support, Framework, Mentoring Relationship, Teaching and Learning, Theory practice gap, Assessment.

TABLE OF CONTENTS

CHAPTER 2

LITERATURE REVIEW

CHAPTER 3

RESEARCH DESIGN AND METHODS

CHAPTER 4
QUALITATIVE ANALYSIS, FINDINGS, AND DISCUSSION OF PHASE 1

CHAPTER 5
QUANTITATIVE ANALYSIS, RESULTS, AND DISCUSSION OF PHASE 2

CHAPTER 6

A CLINICAL MENTORING FRAMEWORK FOR STUDENT NURSES IN MAURITIUS

CHAPTER 7

SUMMARY OF KEY FINDINGS, EVALUATION OF THE FRAMEWORK, LIMITATIONS, CONCLUSIONS, AND RECOMMENDATIONS

TABLES

FIGURES

ANNEXURES

LIST OF ACRONYMS

CLE	**Clinical Learning Environment**
CSN	**Central School of Nursing**
DGN	**Diploma in General Nursing**
MOH & QOL	**Ministry of Health & Quality of Life**
NMC	**Nursing Midwifery Council of United Kingdom**
RCN	**Royal College of Nursing**
UK	**United Kingdom**

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

As a major workforce, nurses remain the backbone of the healthcare system at a global level (Narang 2018:1). They play a critical role in achieving the healthcare goals of the population. In this 21st century, nurses face a wide range of challenges, including the escalating cost of healthcare, an ageing population, technological advancements, changes in diseases patterns, staff shortages, and a critical lack of nurse educators (Fawaz, Hamdam-Mansour & Tassi 2018:106). Despite major transformation in the nursing profession over the last two decades (Caputi 2017:1), nursing education and training have not kept abreast with those rapid changes; particularly in poorly resourced countries (Bvumbwe & Mtshali 2018:1). In order to meet the emerging needs of the nursing profession and the population, nurses need to be trained within an effective and efficient nursing education system. This will prepare them to become critical thinkers, competent and clinically well trained with necessary skills, knowledge and attitudes. Caputi (2017:1) argues that it is becoming imperative to explore new pedagogies and re-think nursing education and clinical training.

One of the major challenges associated with nursing education in this 21st century is the practice preparation of student nurses in this complex healthcare environment for their fitness to practice (Mannino & Cotter 2016:1). Practice training relies largely on mentoring, which is central to the professional development of student nurses (Royal College Nursing RCN 2017; Vance 2014:66). The clinical mentoring of students in the context of Mauritius is mainly undertaken by qualified nurses who act as mentors. This thesis will explore clinical mentoring from both students' and nurses' perspectives to develop a clinical mentoring framework for student nurses in Mauritius.

This chapter provides an overview of the thesis and places the topic under study in context. It sets out by giving the background information of the research problem, the

statement of the research problem, its aim, research objectives, research questions, and significance. The key terms and theoretical framework guiding the study are explained. The methodology is briefly described and concludes with an outline of the key chapters.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Nursing education has globally undergone considerable changes and faces numerous challenges. The training of nurses has been recognised as both complex and challenging (Royal College of Nursing (RCN) 2015). In response to these challenges, a call has been made for greater professionalism *inter alia* through reconsidering the duration of training periods for student nurses, and a hospital-based apprenticeship model of training (Blaauw, Diptilo & Rispel 2015:11).

Mauritius was a British colony until 1968 and is now an autonomous Republic. The training of nurses in the local context has thus been based on the British apprenticeship model. In 2000, the United Kingdom (UK) phased out the apprenticeship model of training for nurses (Nursing and Midwifery Council (NMC) 2008), yet student nurses currently still receive 'on the job' practical training as they form part of the workforce and are remunerated. Until 2013, nurses were trained and awarded a Certificate in General Nursing but thereafter the training moved to a Diploma in General Nursing (DGN).

The Central School of Nursing (CSN), which dates back to 1958, is under the control of the Ministry of Health and Quality of Life (MOH & QOL) and conducts the training. It does not have the status of a college and is affiliated neither to a higher education institution nor to a university. Students undergo practical training in regional hospitals, and this is planned and coordinated by the CSN. The shifting of the certificate to DGN was inevitable as it was an old curriculum which was not reviewed in the past three decades. Furthermore, it was no longer responding to the emerging needs of the profession with regards to training and education. Consequently, the content was updated and revamped to keep it current with global ongoing changes affecting the

nursing profession. The duration of the training for the DGN is three years, during which time the students cover 50percentof the theoretical component at CSN and 50percent of the practical component in clinical settings.

Despite having moved to DGN, the approach of supporting students through mentoring in the clinical setting has remained the same. Qualified and experienced nurses carry out the clinical mentoring of students during their practice placement since this forms part of their duties. This involves guiding and supervising students while they are performing nursing procedures; however, without much emphasis on teaching and assessing of theoretical knowledge. It is also to be acknowledged that these qualified nurses are not trained as educators or mentors. Once the placements are completed, all practice procedures undertaken by the students are entered in a logbook and then signed by the appointed nurse. The clinical mentoring of students is, therefore, service-led rather than educationally driven.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Mentoring started appearing in nursing literature from the 1980s as an innovative approach to support students in the clinical setting, and is currently considered a global strategy to support students during their clinical placements (Jacobs 2018:157). Mentoring ensures that students are equipped with clinical practice skills and the theory-practice gap is thus addressed (Arnesson & Albinsson 2017:202; Tiwaken, Caranto & David 2015:66). Although the many virtues of mentoring are exulted, it is not without its challenges. The UK reviewed its mentoring system, and while there were visibly articulated mandatory standards, concerns remain regarding the effectiveness of mentoring in clinical settings (RCN 2015). The Willis Commission (2012) further pointed out that the future direction of mentorship needs to be debated by nursing regulatory bodies.

While there are established standards regarding mentoring in Western and European countries, there is no unified description of what mentoring is (Shaikh 2017:1). Besides, the practice of mentoring varies widely across clinical settings and contexts. Shaik (2017:3) argues that mentoring is further compounded owing to various terms that are used interchangeably with it. This includes preceptoring, assessing, supervising, coaching and facilitating, which can likely lead to confusion. In spite of the literature abounding on the concept of mentoring, it is not properly understood and defined (Foley & Davis 2017:70). Hence, the lack of a universal definition of 'mentoring' poses a serious challenge for mentors in supporting students in clinical practice.

A complex network of forces within the clinical setting, referred to as the clinical learning environment (CLE) (Zakaria & Raman-Gheith 2015:36), could also influence successful mentoring. The CLE can be challenging and can affect the learning experiences of students positively or negatively, thus promoting or hindering the professional growth of the students (Houghton 2016:48; Papastavrou, Dimitriadou, Tsangaris & Andreou 2016:44).

In addition to challenges posed by the CLE, clinical mentors may also face many hurdles to function effectively in clinical settings, such as the physical space, internal and external factors, organisational culture, and teaching and learning strategies (Flott & Linden 2016:501). Similarly, lack of supervision and practice procedures that are below standards have also been identified as important elements that affect clinical mentoring (Anarado, Agu & Nwonu 2016:20). However, pedagogical knowledge and training of mentors are key pre-requisites to mentoring (Dimitriadou, Papastavrou, Efsthatiou & Theodorou 2015:241). Therefore, mentoring of students in settings which are poorly resourced and lack a pedagogical approach from mentors will likely have a bearing on the quality of the students' training. Jacobs (2018:156) further asserts that mentoring is a construct; it is a phenomenon that is complex and often misunderstood. It includes the integration of individual needs, curriculum objectives, teaching skills and personal qualities of the mentor, the importance of relationships and professional competencies.

The current clinical mentoring system of students in the local context of Mauritius is put into question concerning the extent to which it effectively responds to the clinical learning needs of students enrolled in the new DGN programme. Since clinical mentoring in the local context tends to take a narrow approach, a broader or appropriate framework is needed to address the clinical training needs of students in a more holistic way. In the context of the current debate, it is becoming evident that the clinical mentoring system needs rethinking according to the emerging needs of the training and education of nurses.

This thesis, therefore, seeks to examine the current state of mentoring in the Mauritian context and how effective clinical mentoring can be promoted through the development of a clinical mentoring framework.

1.4 AIM OF THE STUDY

The study aimed to develop a contextually relevant clinical mentoring framework for student nurses in Mauritius to enhance the standard of student nurses' training during clinical placements.

1.4.1 Research objectives

The study was conducted in three phases and the objectives for each phase were as follows:

1.4.1.1 Phase 1 – Qualitative phase

- To explore and describe the qualified nurses' experiences of current clinical mentoring practices.

1.4.1.2 Phase 2 – Quantitative phase

- To investigate the current clinical mentoring practices from both qualified nurses' and students' perspectives.

- To compare the current clinical mentoring practices as perceived by qualified nurses and students.

- To determine whether the current clinical mentoring system responds to the practice learning needs of the DGN programme.

1.4.1.3 Phase 3 – Framework development phase

Based on the findings of the previous two phases, the objective of Phase 3 was:

- To develop a clinical mentoring framework for student nurses in Mauritius.

1.4.2 Research questions

The research questions for each phase were as follows:

1.4.2.1 Phase 1 – Qualitative phase

- What are the qualified nurses' experiences of current clinical mentoring practices?

1.4.2.2 Phase 2 – Quantitative phase

- What are the current mentoring practices within the clinical settings?
- Is the current mentoring system differently perceived by the students and qualified nurses?

- How does the current clinical mentoring system meet the practice learning needs of the DGN programme?

1.4.2.3 Phase 3 – Framework development phase

- What should a clinical mentoring framework for student nurses in Mauritius consist of?

1.5 THEORETICAL FRAMEWORK

A theoretical framework is a theory that the researcher employs to guide and support the study (Imenda 2014:189). It can also be argued as being the blueprint of the whole study (Grant & Osanloo 2014:13). In other words, it gives direction and helps to make sense of the study. However, a theory usually has interrelated concepts and the choice of the framework by the researcher is determined according to the extent to which it will serve as a foundation throughout the entire study.

The foundation of this study was based on Benner's Novice to Expert Framework (1984 cited in Thomas & Kelgren 2017:227) and Grow's (1991) Staged Self-directed Learning Model. Benner's framework draws from the Dreyfus' model of skills acquisition which can be generalised to nursing; it provides the basis for clinical knowledge development and career progression for nursing practice (Benner 1982:403). Additionally, Benner's work (1984) gives a clearer view of how the acquisition of knowledge and skills from education and situational experiences are applied to nursing practice, research and administration (Oshvandi, Moghadam, Moradi, Cheraghi, Borzu & Moradi 2016:3014). Grow's model (1991) emphasises teaching and education at all levels within the organisation. It is based on the situational leadership model of Paul Hersey and Keneth Blanchard, known as the 'Staged Self-directed Learning Model' (Grow 1991:126). Thus, leadership is an important driver within Grow's model, which will likely foster a culture of lifelong learning.

Evidence from the literature indicates that Benner's theoretical framework has been widely used in various nursing studies, but it is scanty with regards to research related to practice training. However, other theoretical frameworks have also been used to study practice training. For instance, Kolb's (1984) and Chinn and Kramer's (1995)models have been applied to support studies regarding practice learning environments (Aliakbari, Parvin, Heidari & Haghani 2015:10).Accordingly, they state it is evident that students will learn and gain practice experience during their clinical placement. For this reason, it is argued that the aim of Kolb's experiential learning is to integrate theoretical knowledge into practice, as Murray (2018:1) puts it. Kolb's (1984) experiential learning encompasses four stages whichthe learner undergoes. This includes diverging (feel and watch), assimilating (think and watch), conceptualising (thinking), and accommodating (feel and do).The author purports that experiential learning facilitates the processing of knowledge into skills, observation, reflection, experimentation and application. Conversely, Grow's model suggests how teachers can better equip students to become self-directed lifelong learners. Furthermore, it also focuses on education and teaching while empowering students towards greater autonomy (Grow 1991:127).

Benner's framework posits that, in the acquisition and development of skill, one passes through five stages, namely the novice, the advanced beginner, the competent, the proficient, and the expert. Hence, it can be argued that these stages capture three key aspects regarding the students' performance; firstly, the ability to use experience and be independent; secondly, to see things holistically and act accordingly; and thirdly, a move from being a detached observer to an active performer. In contrast, Grow's model advocates that the teacher should match the learner's self-directed learning stage to prepare the latter to progress to the advanced stage.

Contrary to Benner's framework, Grow's model has four stages. These are illustrated in Table 1.1.WhileBenner's framework and Grow's model adopts similar stages, both recognise that a learner needs the support of a knowledgeable and skilful person at the very start. The ultimate aim of both models is to empower and produce autonomous

learners, and although Benner's work appears to be more relevant and practical for clinical settings, Grow's model promotes critical thinking, less interaction and favours learning that is student-led (Grow 1991:134). Nonetheless, it would seem the use of both models tends to provide better synergy for clinical mentoring of students in clinical placements as they are geared towards better outcomes.

Table 1.1: Benner's Framework (1984) and Grow's model (1991)

BENNER'S FRAMEWORK(1984)		GROW'S MODEL(1991)
1	***Novice*** - no experience, still at school	***Dependent*** - the learner relies on the teacher and learns through coaching and his authority
2	***Advanced beginner*** - starts following rules and protocols in an attempt to perform	***Interested*** - strong interaction regarding the subject matter between learner and teacher through guiding and motivating
3	***Competent*** - starts doing through experience and are task-orientated	***Involved*** - acquisition of knowledge and skills, and ready to face challenges where teacher acts as facilitator
4	***Proficient*** - ability to see problems as a whole, act alone and take decisions following broad experience	***Self-directed*** - feeling confident and willing to take responsibility and being independent. Teacher steps in as consultant or delegator
5	***Expert*** - Performs at a high level, readiness to take responsibility and face any situation due to extensive experience	

The choice of Benner's framework and Grow's model for this study stems from the fact that mentoring takes place within the CLE. Moreover, the stages within both models to a great extent reflect the pathway through which students undergo training during their

clinical placements. It is within this context that the mentors interact, learn and teach students, which in turn contributes to the professional growth of both the students and the mentors. Benner's model is not related to trait but is rather a situational one, where an inexperienced nurse or student will apply knowledge and skills according to situations (Thomas & Kellgren 2017:229). Furthermore, the framework allows nurses and students to build on their actual experiences to enhance their practical knowledge and skills (Oshvandi et al 2016:3018). Vance (2014:66) argues that the mentoring model is based on the premise of novice to expert since the mentee always starts as a novice and ultimately becomes an expert with experience and time. The acquisition of knowledge and skills comes with time through sound education and experience, grounded through the professional career of the student nurses. Also, there is the element of pedagogy in Benner's framework as it allows flexibility in responding to the individual and educational needs of students according to the levels of their progress (Thomas & Kellgren 2017:229).

Despite Benner's theory having its merits, it also has limitations. It does not focus on the education of the learner but on the acquisition of knowledge through experience. Moreover, its non-empirical nature has been identified as a major setback (Oshvandi et al 2016:3019). However, Grow (1991:127) asserts that a theory does not need to be right to be useful. In this study, the use of Benner's framework along with Grow's model provides an alternative to better address the researchable problem more holistically.

1.5.1 Assumptions

Assumptions are principles that are believed to be true although they have not been proven or tested (Grove, Gray & Burns 2015:42). This study was based on certain assumptions held by the researcher while developing this thesis.

- Students should be self-directed, lifelong learners instead of remaining dependent.
- There is more than one way to teach and learn.
- Dependent learners need support.

- The notion of knowledge and skills are embedded within the CLE.
- Students undergo professional growth during practice learning which is dynamic and contextual.
- The ability for a student to be self-directed is situational, while one can also be dependent.
- Self-direction can be learned and taught.

1.6 SIGNIFICANCE OF THE STUDY

The mentoring system in the local context has remained static for decades. This study sought to focus on the formulation of a framework for clinical mentoring relevant to the local context and current demands. It also provided an updated review on the topic drawn from different sources. The data collection instrument included new variables that have not previously been measured by existing instruments. The outcomes of this study could thus serve as baseline information for future research. It is anticipated that the framework drawn from this study would assist in implementing an effective clinical mentoring system in Mauritius.

The introduction of this framework would further add a new dimension to students' practice placement, thereby enhancing the clinical practice and upholding the standards of students' clinical training. It would also set the foundation for a new orientation to bridge the theory-practice gap, particularly with regards to the recent introduction of the DGN while meeting the long-term needs of the practice training. Likewise, this framework might also be transferable to other paramedical disciplines, where applicable, in the context of workforce capacity building to respond effectively to emerging challenges.

1.7 DEFINITIONS OF KEY TERMS

For this study, the following description of terms is applied.

1.7.1 Clinical

The term ‘clinical’ is usually associated with medicine and relates to the examination and treatment of patients in hospitals (Oxford online dictionary 2018). In this study, the term ‘clinical’ is associated with wards (a division in the hospital shared by patients), also referred to as ‘clinical settings ’and ‘clinical learning environment (CLE)’ where student nurses are allocated during their clinical practice placement.

1.7.2 Mentoring

Mentoring involves a relationship between an older experienced person and a younger person with less experience, where the experienced person acts, guides, counsels and advises the younger person (Fulton 2015:42). Mentoring also refers to the ability of the mentor and the protégé (mentee) to develop a reciprocal relationship, which is built on trust, communication, and respect (Baxley, Ibitayo & Bond 2014:xxxvii). Mentoring in the context of this study is a shared formal relationship between an expert mentor and a mentee in which personal and professional growth is achieved through supervision, teaching, assessment, and engagement with each other. This takes place within the CLE.

1.7.3 Framework

A framework refers to the logical structure of meaning, such as part of a theory that guides the development of a study and facilitates the integration of findings to the body of knowledge (Grove et al 2015:2015). With regards to research, a framework guides the researcher in examining, explaining, interpreting and conceptualising the phenomenon under study (Imenda 2014:188). This structure provides directions to proceed systematically to achieve the desired outcomes. In this study, a framework refers to the designed and systematic structure representing the integrated findings to better support clinical mentoring.

1.7.4 Student nurse

Student nurses in Mauritius are students enrolled in a prescribed nurse training programme (Nursing Council of Mauritius 2003). In this study, 'student nurses' refer to third-year students who are pre-registrants, and who are posted in clinical placements and following the DGN course.

1.8 OPERATIONAL DEFINITIONS

The main purpose of an operational definition is to define how the concepts will be empirically measured (Grove et al 2015:509). The concepts central to this study were operationalised as follows:

1.8.1 Mentoring

Mentoring is the facilitation and support provided by experienced qualified nurses in imparting knowledge and enhancing the clinical skills of students. Mentoring was measured using a designed questionnaire based on the Clinical Environment Inventory scale (CLEI) (Ali, El Banan & Al Seraty 2015:4) and the Clinical Learning Supervision Evaluation Scale (CLESE) (Choudhary, Kumar & Kumari 2014:11-15).

1.8.2 Clinical learning environment

The clinical learning environment (CLE) was measured using the modified CLEI scale in the questionnaires. These 79 items, with six-point Likert scales, included all variables related to the CLE. Further discussion on these tools will be addressed in Chapter 3.

1.9 RESEARCH DESIGN AND METHODS

The terms ‘research design’ and ‘research methods’ are often used interchangeably, yet they have different meanings. Design refers to the overall study plan or strategy which will allow us to answer our research question; that is, it incorporates the researchable problem and the whole research process (Durand & Tracey 2014:30). Research methods focus primarily on the practice and techniques used to collect and analyse data (Bowling 2014:166). Research methodology also requires a precise description of the data collection tool and the context in which it takes place (Cresswell & Cresswell 2018:32). Thus, the research designs and methods require the researcher to describe and give clarity regarding the strategies and processes followed to maintain the integrity of the study.

1.9.1 Research design

A descriptive, exploratory, sequential, mixed-method cross-sectional design was used in this study. This design requires the use of both qualitative and quantitative approaches with the eventual integration of the data generated from both sources (Denscombe 2014:13). The mixed method lies within the continuum of qualitative and quantitative designs since it attempts to integrate the elements of these paradigms (Leavy 2017:267). The use of a mixed method allows viewing a problem from different angles and is based on ‘what works best’ for addressing specific problem (Denscombe 2014:140). The mixed method is associated with three designs, namely the convergent parallel mixed methods, the explanatory sequential mixed methods, and the exploratory sequential mixed methods (Cresswell & Cresswell 2018:295). This study followed the exploratory sequential mixed methods andwas conducted in two phases.

Phase 1 consisted of the qualitative phase. Qualitative designs tend to understand human experiences and attitudes from the perspective of those being studied (Grove et al 2015:509). This is also referred to as being interpretive since an attempt is made to give meanings to concepts expressed by people within their world (Durand &Tracey

2014:44). This phase was exploratory since the idea was to elicit new information and provide insight for better understanding of the phenomenon (Grove et al 2015:165), and secondly to enhance the measurement tool used in the second phase.

Phase 2 adopted a quantitative approach based on the principles of positivism which assumes that phenomena are measurable using the deductive principles of the scientific method (Bowling 2014:132). This phase employed descriptive cross-sectional design. This design allows collecting the same data from the population of interest at one point in time (Leavy 2017:269).

In the final phase, the findings were synthesised using Dickoff, James and Wiedenbach's (1968) survey list to develop a clinical mentoring framework for student nurses.

1.9.2 Research method

The population, the sample, rigour of the method, ethical considerations and data analysis are briefly outlined. These concepts are described in more detail in Chapter 3.

1.9.2.1 Research setting

Mauritius is an island situated in the south-east of Africa, East of Madagascar in the Indian Ocean. It has a surface area of 2040 square kilometres, which is divided into nine districts and five health regions. According to the Central Statistical Office (2008), the population estimation was1269668 people by mid-June 2018. Mauritius is a multi-racial society, consisting mainly of Hindus, followed by Creoles (Afro Mauritians), Muslims, Chinese, and Franco Mauritians. The major religions include Hinduism, Islam, Buddhism and Christianity. Mauritius has a free education system from primary to university level. There are five public regional hospitals across the island and other speciality hospitals through which free health service is provided to the public. There are

also medi-clinics and community health centres which form part of the primary healthcare system. There are two private hospitals and five private clinics.

The training of nurses is undertaken by the CSN which is under the aegis the MOH & QOL, while there is also a private institution that provides training for nurses.

1.9.3 Population, sample and sampling

The population refers to all the study elements with the same characteristics in which the researcher is interested (Grove et al 2015:509), while a sample is a subset of the population from whom data will be generated (Leavy 2017:268). The process of drawing the sample from the population is known as sampling as it tends to yield reasonably accurate findings without collecting data from the whole population (Bowling 2014:199).

In this study, the target populations were qualified nurses and student nurses posted in the five regional hospitals of the island of Mauritius. The qualified nurses included those who had already completed their top-up Diploma programme, and the students were third-year students who were on practice placement in clinical settings. The nurses' population size was 996 (N=996) according to the registers of regional hospitals, while that of students were200 (N=200) according to the register of the CSN.

A non-probability sample was used for the qualitative phase of the study. In this sample, all participants have a known chance of being selected (Leavy 2017:265). Purposive sampling was used since the participants were consciously chosen by the researcher based on their knowledge on the phenomenon under investigation (Grove et al 2015:2015). Initially, the sample size proposed was in the range of 10-30. The final sample size for this phase was eight (n=8), as saturation was achieved after the sixth interview. Two additional interviews were conducted to confirm data saturation.

Probability samples were used for the quantitative phase of the study. In other words, participants were chosen using random procedures (Grove et al 2015:258). Simple

random sampling was used to choose both qualified nurses and student nurses in this second phase. This technique gives equal probability to all participants to be selected for the study (Grove et al 2015:509). The sample size for qualified nurses was n=285, and that of student nurses was n=130. The sample sizes were calculated in consultation with the statistician. However, after the data completion phase the final sample sizes for nurses were n=255, and students n=115, respectively.

1.9.4 Data collection

Data collection for this study took place in sequential phases in all regional hospitals. In the first phase of the study, qualitative data were collected in clinical settings. In this phase, face-to-face semi-structured interviews were held with participants, which included only qualified nurses as they supported students' learning and acted as mentors. Semi-structured interviews usually involve a fixed set of questions which allow the researcher to use probes and prompts to gather further useful information (Grove et al 2015:83). An interview guide was used to collect data, as this allowed flexibility for both participants and the researcher to probe and raise points that may not be covered during an interview (Bowling 2014:276). Findings from Phase 1 of the study were then used for the design of the data collection tools for the next phase. Quantitative data for the second phase were collected from both student nurses and qualified nurses using structured questionnaires. Self-reported questionnaires included closed-ended questions administered to participants. In both cases, the data collection instruments were piloted prior to its use.

1.9.5 Data analysis

Since a mixed method was used in this study, measures were taken for the data collected from both methods to comply with the design processes. Analysis of qualitative data was based on thematic analysis. According to Nowell, Noris, White and Moules (2017:3), thematic analysis is considered a useful method for qualitative analysis, as it allows comparing, highlighting and examining differences and similarities

among participants. This consisted principally of reviewing all audio-recorded interviews and field notes to give meaning and categorise them into clusters and themes.

Quantitative data were analysed using computer software SPSS 21.0. Descriptive statistics were used to describe all the variables in terms of percentages, means, and range of scores as performed in the descriptive analysis (Cresswell & Cresswell 2018:328). Standard deviations were used as inferential statistics to observe differences.

1.9.6 Data integration

Since the design of the study involved two approaches, the data collection processes yielded both qualitative and quantitative findings. The analyses of these findings and the combination of both result in unambiguous interpretation, also referred to as data integration (Pluye, Bengoechea, Granikov, Kaur & Li Tang 2018:45). Thus, the integration of data also helped in identifying similarities and differences in the findings. In this study, data integration was considered during the design of the questionnaire for the second phase and interpretation of its findings, as well as during the design of the framework.

1.9.7 The development of the clinical mentoring framework

One of the purposes of research is the development or generation of theory, which provides insights to better understand and express ideas for the essence of nursing practice (McEwen & Wills 2014:73). In spite of theory usually guiding practice, it needs to be discussed, explained and understood for the positive influence of health outcomes of patients (Saleh 2018:18). In this study, relevant concepts were identified and explained from the findings of the study to establish relationships which are illustrated within the clinical mentoring framework, as shown in Chapter 6. This was based on the mapping survey list as described by Dickoff, et al. (1968). The approach and development process of the framework are further outlined and described in Chapter 6.

1.10 RIGOUR IN RESEARCH

The concept of rigour within research revolves centrally around the reliability and validity of the data; that is, from its collection to the contribution of the outcomes of the study and the reduction of bias (Cresswell & Cresswell 2018:335). Therefore, maintaining the rigour of a study requires the researcher to be diligent when collecting, analysing and interpreting data. Bowling (2014:160) claims that rigour can be attested if an independent investigator reviews the same data and methods used to draw the same conclusion. Hence, rigour is a key element to be considered in enhancing the credibility of study findings; this can only be reflected ifthe researcher maintains consistency regarding the overall quality of the research process.

In this study, rigour was observed during both phases to ensure the reliability and validity of the data. While the terms ‘reliability’ and ‘validity’ are associated with quantitative studies, ‘trustworthiness’ is the concept used to describe reliability and validity for qualitative studies. It refers to the extentto which all aspects of the qualitative research process have been observed by the researcher to enhance its credibility (Grove et al 2015:5).

1.10.1 Trustworthiness of the qualitative phase

Trustworthiness refers to the extent to which the researcher has observed rigour in the conduct of the study in order to enhance the quality of the research (Mabuza, Govendor, Ogunbanjo & Mash 2014:3). According to Grove et al (2015:392), this includes confirmability, which relates to objectivity, transferability, which refers to generalisability, credibility, which is linked to internal validity, and dependability, which is synonymous of reliability. The criteria are discussed in detail in Chapter 3.

1.10.2 Validity and reliability of the quantitative phase

Reliability refers to the internal consistency of the instrument and the degree to which it is free from random error, while validity is an assessment of whether an instrument measures what it aims to measure (Cresswell & Cresswell 2018:333). All steps were taken to ensure the issue of reliability and validity during data collection in the quantitative phase. The instruments used were designed following the literature review in consultation with the promoter and the statistician. The instruments were also pre-tested through a pilot study. Validity and reliability are fully addressed in Chapter 3.

1.11 ETHICAL CONSIDERATIONS

Ethical principles must be observed to protect the integrity of the research and the participants, irrespective of the method used (Cresswell & Cresswell 2018:102). The author also suggests that ethical issues should be considered before conducting the study and particular emphasis should be placed on the collection of the data from the participants, its reporting, sharing and storing. In general, full information must be provided to participants in a study, and there are basic ethical principles that must be observed (Grove et al 2015:519). These are beneficence, respect for human dignity, justice, informed consent, and confidentiality procedures. In short, participants should not be harmed, should give consent for participation and their rights should be respected.

This study was also guided by scientific principles, and every attempt was made by the researcher to comply with the ethical principles governing the conduct of the study. Before the start of the study, ethical clearance was obtained from the Research Ethics Committee, Department of Health Studies of the University South Africa (Annexure A), and the National Research and Ethics Committee of the Ministry of Health and Quality of Life (Annexure B). A permission letter (Annexure C) was presented to respective gatekeepers of all regional hospitals where data were collected. Ethical aspects are explored in-depth in Chapter 3.

1.12 STRUCTURE OF THE THESIS

The thesis consists of seven chapters which have been organised as follows:

Chapter 1: Provides the orientation to the study and briefly outlines the key steps of the research process.

Chapter 2: Covers the literature review from relevant studies, articles and discussion papers on the topic being studied.

Chapter 3: Describes the research design and methods adopted for the study.

Chapter 4: Presents and discusses the qualitative findings of Phase 1.

Chapter 5: Presents and discusses the quantitative results of Phase 2.

Chapter 6: Describes the clinical mentoring framework for student nurses in Mauritius.

Chapter 7: Summarises the key findings, evaluates the framework, includes the conclusions drawn from the data analysis, limitations of the study, and provides recommendations.

1.13 SUMMARY

This chapter provided an overview of the study. The background to the research problem, justification of the study, its aim, research objectives, and research questions were presented. The theoretical framework underpinning this study was discussed and relevant concepts were presented. The research design and methods were briefly outlined, and the development of the clinical mentoring framework was addressed. The literature review central to the topic of study follows in Chapter 2.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

A comprehensive review of the literature was undertaken to obtain an overview of the studies that have been conducted previously and what is currently known about the focus of the study. A literature review serves many purposes but central to it is organising, synthesising and summarising the key issues related to the topic under study (Leavy 2017:263). It also helps to point out inconsistencies, gaps and contradictions while attempting to explain 'why', 'how' and 'when' things happen in a phenomenon (Rowe 2014:243). The literature review guides the researcher in terms of the boundaries within which relevant studies and factual information are available on the topic to avoid duplication.

This chapter presents the current state of knowledge on the topic, drawn from textbooks, discussion and opinion papers, and academic journals. Both empirical and non-empirical studies were considered. To broaden the scope of the search, references in recently published studies and relevant abstracts were scrutinised as well. The search was limited to the period 2015 – 2019 to have the latest update on the topic. A few empirical and non-empirical articles and books that date before 2015 were also consulted because of their historical nature and for being still pertinent to the topic. The literature review was conducted from a broader perspective, to gain better insight across other disciplines such as education, business, and medicine. Electronic sources were used to retrieve articles from the following databases; CINAHL (Cumulative Index to Nursing and Allied Health), MEDLINE, Pub Med, Google Scholar, OVID and EBSCO. The keywords used were 'mentoring', 'clinical learning environment', 'learning theories' and 'theory and practice gap'.

This review firstly seeks to provide an overview of the definitions of mentoring and it also explores the factors that directly or indirectly impact on mentoring. It then uses the

methods of Walker and Avant (2011) to grasp the relevant points and findings for a synthesis to understand mentoring as a concept. Finally, it examines the inextricable link of the CLE to mentoring. For this reason, the content of the review is structured and developed under four main headings; the origin and definition of mentoring, the factors influencing mentoring in nursing, analysis of the concept of mentoring, and the clinical learning environment.

2.2 THE ORIGIN AND DEFINITION OF MENTORING

Early evidence shows that the concept of mentoring dates back to ancient Greek mythology and has only been actualised in the social world from late 1910 (Irby & Boswell 2016:1). According to Greek mythology, in Hommer's Odyssey, Odysseus left his son to his friend Mentor during his absence to be his trusted guardian (McMahon 2016:1). Since then, the term ‘mentor’ has been used across various disciplines such as education, law, business, community settings, and psychology.

Mentoring is not a new phenomenon to nursing as it also dates back to the time of Florence Nightingale who was referred to as the mentor of matrons (Olaolorunpo 2019:142). Within nursing, mentoring is increasingly being recognised as key support for the professional development of students and nurses, and more importantly vital to student nurses’ education (Matin 2017:1; Sambunjak 2015:47). Mentoring has been described as a relationship between an old experienced person and a young one with less experience, where the older one acted, guided, advised and counselled the young one (Fulton 2015:42; McMahon 2016:2). Most definitions on mentoring tend to include all these elements; for instance, Dorsey and Baker (2004:260) define a mentor “as a wise and trusted advisor, counsellor, or teacher who has something to offer that meets the immediate needs or future needs of another”. Similarly, Matin (2017:1) emphasises that mentoring involves guiding, counselling, teaching, and sharing of experiences to a mentee. Mentoring should be formal when it relates to the relationship between an experienced professional and an inexperienced professional (Grossman 2013:2).

Formal mentoring is established, planned and structured by the organisation where the relationship between the mentor and the mentee is formalised (Green & Jackson 2014:79; Venant 2018:2) according to a set of principles (Carlson 2015:1). Formal mentoring involves a supportive relationship, common goals and commitment to achieve positive outcomes (Venant 2018:3) while remaining the widely preferred approach for students' training in practice settings (Oluchina & Amayi 2016:179). Arguably, overlooking these aspects of mentoring could likely affect the personal and professional development of both mentees and mentors, which can eventually impact negatively on the quality of care. To date, there is still not a common definition within the nursing literature regarding mentoring since there is lack of agreement on the poorly defined roles of mentors (Matin 2017:1; RCN 2015).

2.2.1 Definitions of mentoring within nursing

The definitions of mentoring abound within the literature but are elusive and not well conceptualised (McMahon 2016:2). Most of the definitions in the literature on mentoring in nursing are from regulatory and professional bodies from Western and European countries. The UK emerges as being the only country which has a clear policy on mentoring students in CLEs (RCN 2015). Despite this assertion, the mentoring system has raised concerns, and suggestions have been made for its complete overhauling to better meet the practice learning needs of students (Lakasing & Francis 2005:41). The RCN (2015) highlighted in its report that although standards have been established for mentoring across the UK, its effectiveness still raises concerns. To that end, the NMC of the UK has recently announced significant changes to education standards in replacement of the traditional mentorship with the introduction of "academic assessors", "practice assessors" and "practice supervisors" (Duffy & Gillies 2018:17).

The definition of mentoring from the NMC (2008) is predominant in the literature, and the mentor has been defined as someone "who facilitates learning, supervises and assesses students in the clinical setting and has set standards to support learning in practice". The Canadian Nurses Association (2004) considers a mentor "as an

experienced and knowledgeable leader who supports the maturation of a less experienced person with leadership potential (mentor)" while the Nursing and Midwifery Council of New South Wales, Australia (2011), recognises a mentor "as an experienced and trusted advisor who is recognised as highly competent in his / her field and provides mentoring assistance to the mentee". In support of these evolving definitions, Vance (2014:66) states that the Odyssey story is still relevant today and affirms that "mentoring is developing and empowering each other through relationships and connections that lead to professional and personal development and leadership skills". The author claims that the traditional model of mentoring promotes elitism and is exclusive, dyadic, expert-to-novice, and patriarchal. This view is supported by Matin (2017:3), who also adds that "mentoring is a dyadic long-term reciprocal process between a mentor and mentee for skills and knowledge acquisition for the effective role change in the nursing profession". Nonetheless, the key attributes associated with mentoring has been highlighted following the concept analysis of mentoring. Other authors (Hodgson & Scalan 2013:391; Olaolorunpo 2019:143) have identified mutual relationship, professional growth, leadership and sharing of knowledge as being essential qualities.

In their study, Mijares, Baxley and Bond (2013:16) argue that the concept should be seen within the complex system of globalisation owing to its use in various disciplines. In this study, five disciplines were considered, namely education, business, anthropology, social work, and psychology. An analysis of the use of mentoring within these disciplines indicated that they shared similar terms and ideas to nursing. The authors concluded with the following definition: "Mentoring is defined as an interpersonal interaction between a seasoned mentor and a novice protégé (mentee), which includes supporting, guiding, teaching, encouraging, and role-modelling". The various definitions from the regulatory bodies tend to give direction for the practice of mentoring according to standards, while Seekoe (2014:137) concludes that the purpose of mentoring is capacity building, empowerment, and development of competencies. In line with these definitions, other paramedical disciplines draw from the same principles of mentoring to that of nursing. This includes medicine, physiotherapy, and pharmacy where mentoring is viewed as the sharing of knowledge between an experienced

practitioner and a trainee, proper guidance, along with a reciprocal relationship (Keane & Long 2015:7; Witry, Nguyen & Patterson 2015:2). However, there are other forms of support which are often associated with mentoring.

The term ‘mentoring’ is variously constructed so it can easily be linked to assessing, supervising, preceptoring and coaching; in fact, these elements are present in a mentoring relationship (Green & Jackson 2014:80; Peak & Kelly 2016:19). Although these terms are interchangeably used, they have different meanings.

Assessing is a critical element of mentoring which involves the assessment of students in clinical practice by specially trained mentors (Douglas, Garrity, Shepherd & Brown 2016:34; RCN 2017), while clinical supervision is a formal process which involves the guidance and monitoring of practice of trainees to promote their independence (Moxham & Gagan 2015:36). Similarly, preceptoring is a teaching and learning process that facilitates preceptees or newly qualified registrants to achieve new knowledge, skills and attitudes with support from experienced preceptors in clinical practice (Miller, Vivona & Roth 2016:2015). In contrast, coaching is a form of learning support which attempts to empower the trainee to adapt to professional changes (Walker-Reed 2016:43). Thus, mentoring can be perceived as an umbrella term owing to a lack of standards regarding its practice.

2.2.2 Standards in mentoring

In general, practice-based disciplines entail that basic standards are observed by practitioners. Indeed, mentors are in a better position to reinforce standards of practice and promote professional values, compliance, and governance through established standards (Duffy 2015:50; Fulton 2015:49). The regulating of mentoring practice is done to ensure that standards are applied to the assessment of pre-registration students for their fitness to practice, thereby protecting the public (Hardman 2016:4). However, existing constraints within the CLE could likely affect the quality of mentoring, thereby

compromising the standards. Conversely, most of the standards within the CLE are either partially met or go unmet (Zakaria & Rahman-Gheith 2015:35).

To uphold standards in practice settings, the NMC (2008) has made it explicit that mentors must meet certain key criteria and competencies. These competencies address key aspects of pre-registration nursing education and determine students' fitness to practice. These are summarised in Table 2.1. One of the mandatory criteria is that the mentor should have completed an NMC-approved mentor preparation programme. However, the NMC (2008) document does not make provision for how mentors should manage CLE and how to deal with its potentially challenging situations (Brand 2016:5).

Table 2.1: Competencies for mentors

1	Establishing effective working relationships	5	Creating an environment for learning
2	Facilitating learning	6	Context of practice
3	Assessment and accountability	7	Evidence-based practice
4	Evaluation of learning	8	Leadership

The need to devise new mechanisms to share best practices and educational approaches in mentorship is vital to maintain standards (RCN 2015). Suffin and O'Mahoney (2014:15-17) argue that those who have shown leadership skills with regards to NMC (2008) competencies should be upgraded to lead mentors as they can work with practice educators to lead the mentors in an effective way. However, developing and demonstrating the eight competencies would likely require mentors to focus on the educative and supportive aspects of mentoring to maintain standards. One of the purposes of setting standards is to ensure consistency in the support of practice learning and assessment. Nonetheless, the underlying factors that hinder the implementation of standards need to be addressed.

2.3 FACTORS INFLUENCING MENTORING IN NURSING

Many studies (Al-Hamdam, Fowler, Bawadie, Noorie, Summers & Debbie 2014:248-256; Anarado et al 2016:1-20; De Abreu & Interpeler 2015:42-46; Foster, Ooms & Marks-Maran 2015:18-24) have focused on the factors influencing mentoring in nursing. Al-Hamdam et al (2014:249) reported that students identified the relevant knowledge and skills of mentors as being the most important qualities. The authors also emphasised that the clinical teaching expertise of the mentor is vital for quality mentoring of students during their practice placement. De Abreu and Interpeller (2015:45) also found that students' concerns are related to three areas of mentoring. This includes the mentor's qualities and ability to facilitate learning, the mentoring relationship and decision making in complex situations, as well as support and positive feedback. Likewise, Rylance, Bareth, Sixmith and Ward (2017:407) noted that assessing and supporting students in achieving their goals and developing competencies are key factors that need to be considered during mentorship.

Nonetheless, in a systematic review of qualitative studies, Peake and Kelly (2016:18) reported that mentors should facilitate the integration of students within their clinical placements, provide the right experience, and instil professional attitudes. For this reason, the mentor's engagement in the mentoring process is critical. Setati and Nkosi (2017:136) found that responsive feedback from trained mentors, adequate resources and mutual responsibility contribute to promoting effective mentoring and reducing the theory-practice gap. This implies mentors must always ensure that clinical settings meet the requirements for the practice placement of students, perform according to professional standards and share their knowledge and experiences to integrate theory into practice. In essence, mentors' roles appear multifaceted and their personal qualities and characters are the hallmark of mentoring (Sabog, Caranto & David 2015:5).

2.3.1 Qualities of mentors

The profile of the mentor in terms of skills, competencies and qualities are at the heart of nursing education (King's College 2013). Greenfield (2015:29) suggests that the role of the mentor should primarily focus on five elements. He/she should be a supporter, supervisor, teacher, assessor and trustworthy. Other qualities that mentors should demonstrate are role modelling, open communication, passion and inspiration, mutual respect, being approachable and adaptable, empathy, good interpersonal relationship, teaching and clinical skills (Goldie, Dowie, Goldie, Cotton & Morrison 2015:36; Eller, Lev & Fleurer 2014:818; Vinales 2015:532). Further attributes include knowledge and honesty (Heeralall 2014:246), while respect and professional competencies are the top-most qualities of mentors and clinical teaching behaviours impact largely on the integration of theory into practice (Sabog et al 2015:5).

Given the multitude attributes associated with mentoring, it proves difficult as to what constitutes the minimum essential characteristic to determine the effective mentor (Gangadharan, Al Wahed & Ali Assiri 2016:651). Despite mentors requiring the specified desired qualities, it is also important to understand and recognise their roles. Matin (2017:3) argues that the key roles of mentors involve the sharing of knowledge and skills, providing psychosocial support, encouraging students to engage in academic activities and research while complying with ethical principles. A mentor's behaviour has a significant impact on a student's experience (Traynor & Mehigan 2015:13); a good mentor-mentee relationship thus contributes to successful mentoring experience (Muleya, Marshall & Ashwin 2015:581). This also means that the qualities and roles of the mentors should be given due attention as they are perceived as being crucial to good mentoring (Al-Hamdam et al 2014:225).

It can be argued that the characteristics, roles, and responsibilities appear to be embedded within the qualities of the mentors. Nonetheless, there are converging views that good mentors should be able to teach effectively, have clinical competencies and sound interpersonal skills (Lee, Clarke & Carson 2018:103; Tuomikoski & Kaariainen

2016:98). While good qualities of the mentors and positive factors of the CLE have a significant impact on mentoring, there are also various barriers that affect mentoring.

2.3.2 Barriers to mentoring

In general, there are system factors within the health system that hinder effective mentoring (Anarado et al 2016:1-20). This includes the lack of supervision of students in clinical practice by teachers, inadequate preparation on theoretical and practical aspects before being posted in their clinical placements, lack of equipment, and absence of follow-up during shifts. Additionally, overcrowded facilities, workload, poor feedback, and staff shortage have been found to inhibit clinical performance (Dlama, Modupe & Umar 2015:57). A lack of motivation from students, role modelling and knowledge gaps between qualified nurses and tutors have also been recognised as factors that can affect mentoring (Mwale & Kalawa 2016:1). Baraz, Memarian and Vanaki (2015:57) further add that the incompetency of clinical instructors, such as the use of poor instructional strategies, poor teaching skills, inconsistent evaluation processes and being autocratic and inflexible towards students can negatively impact on the professional growth of the students. This is usually viewed as negative experiences by students, and such mentors are referred to as “toxic mentors”, as pointed out by Darling (1985 cited in Vinales 2016:51).

Furthermore, poor collaboration among staff, the absence of qualified nurses, aggressive behaviour of patients, bad caring experiences and unwelcoming staff have been perceived as a stressful psychosocial environment (Baraz et al 2015:61). Likewise, in a recent review, Rylance et al (2017:4-9) highlighted that mentors feel frustrated and constrained by the work environment’s pressure. Conversely, students also face challenges in the CLE; the roles of the students have raised questions as to whether they should form part of the workforce or just get involved passively in certain clinical tasks. The NMC (2010) made it clear that students should have supernumerary status, implying that they should not be employed to provide nursing and midwifery care. This can negatively impact on mentors, students, and patients (Shepherd & Uren

2014:18) as it does not promote learning (Anarado et al 2016:4). Thus, the supernumerary status restricts students from being actively involved in the caring of patients and performing clinical procedures, unless being supervised, thereby impacting on their clinical and learning progress.

Various barriers thus negatively affect mentoring, and the poor mentoring relationship could be one such barrier. Mentoring relationships have been considered a key element that contributes to the teaching and learning process of both mentors and students (Eller et al 2014:820). The meaning of mentoring relationships within nursing, in particular, is unique and this is further explained next.

2.3.3 The mentoring relationship

A mentoring relationship encompasses both professional and interpersonal relationships between the mentor and mentee, while it remains the single most crucial factor for effective mentoring (Ali et al 2015:2; Lawal, Weaver, Bryan & Lyndo 2016:37). It also promotes the professional development and success of both mentors and mentees (Manister & Frederickson 2016; RCN 2017). Effective relationships in clinical settings are based on the acceptance of each other through mutual respect, trust, understanding, constructive feedback, and awareness of intrapersonal and interpersonal skills (Setati & Nkosi 2017:137). The mentoring relationship requires nurturing, caring, engagement and investment of effort, time and ongoing communication (Potter & Tolson 2014:729). Yet one of the challenges that mentors usually face at a global level is related to their ability to provide, in all fairness, equal support and learning opportunities to all mentees (Eller et al 2014:816). Moreover, Strauss, Johnson, Marquez and Feldman (2013:86) found that a successful mentor-mentee relationship is based on five key elements. These are reciprocity, mutual respect, clear expectations, personal connection, and shared values.

The mentoring relationship usually takes the form of socialisation (Mokgele & Caka 2015:1263) as it is a complex interactive process which involves learning, interaction,

development and adaptation (Dinmohammadi, Peyrovi & Mehrdad 2013:26; Goodare 2015:38). These four attributes are apparent and demonstrated in the mentoring relationship in clinical settings. Socialisation is therefore embedded in a relationship and is an ongoing process which continues throughout one's career until the mentors and mentees become fully adjusted insiders (Houghton 2016:49). However, the mentoring relationship has also been found to be the least important overall characteristics of clinical instructors (Sabog et al 2015:7), but this could be attributed to cultural differences. While communication and openness between the mentor and student appear to be important elements to sustain mentoring relationships, the behaviour of the mentor as a role model has a profound influence on inspiring students (Vinales 2015:532). Furthermore, from an ethical perspective, mentoring relationships could be problematic when there is abuse with regards to authority and power, such as being exclusionary and discriminatory (Green & Jackson 2014:82).

Drawing from the existing definitions of mentoring and the outlined factors, the mentors' challenges seem related to their ability to pass on skill and knowledge, adapting to constraints of the clinical environment, shaping professional growth of the students and providing learning support. Likewise, the focus of mentoring is on shaping professional development with the main emphasis on knowledge, attitude, and skill. Moreover, as a concept, mentoring is differently understood and practised across various settings owing to the lack of a universal definition. This suggests that mentoring is still viewed as an overarching concept which is not easy to grasp. One approach to make sense of a poorly understood concept is through concept analysis, as described by Walker and Avant (2011). In the section that follows, this method is used to synthesise the relevant points and findings that were highlighted to gain an understanding of mentoring in nursing.

2.4 ANALYSIS OF MENTORING AS A CONCEPT

Concept analysis helps in analysing attributes and clarifying overused vague, ambiguous nursing concepts by contributing to theory development and producing a

precise operational definition (Foley & Davis 2017:70; Liu, Avant, Aungsuroch, Zhang & Jhiang 2014:70). According to Walker and Avant (2011:130), a concept analysis follows a process by firstly identifying the uses of the concept, determining defining attributes, identifying model, borderline, related, contrary, and illegitimate cases, identifying antecedents and consequences, and defining empirical referents.

2.4.1 Uses of the concept

The first and second steps of Walker and Avant's (2011:160) approach involve the identification and use of the concept. The practice of mentoring forms part of a range of disciplines and a common view forming part of many definitions is the "support provided by an experienced person to someone who is less experienced through a relationship" (Fulton 2015:42). An analysis of the term 'mentoring' across five disciplines – education, psychology, social work, anthropology and business – noted that the use of mentoring within these disciplines is almost the same (Mijares et al 2013:7). The authors viewed mentoring "as an interpersonal interaction between a seasoned mentor and a novice protégé (mentee), which includes supporting, guiding, teaching, encouraging, and role-modeling". Similarly, mentors from the fields of medicine, occupational therapy, and pharmacy found mentoring as the sharing and passing of knowledge from an experienced and expert practitioner to a trainee through guidance and a reciprocal relationship while also focusing on personal and professional growth (Keane & Long 2015:7; Witry et al 2015:2). Definitions of mentoring within nursing are mainly from regulatory body perspectives which primarily involve the facilitation of learning, supervision, and assessment of students in clinical settings (NMC 2008; Nursing and Midwifery Council of New South Wales Australia 2011).

2.4.2 Defining the attributes

According to Walker and Avant (2011:162), attributes provide a broader insight into a concept, which are characteristics that are commonly associated with a concept. Within the literature, some defining attributes of the mentor were evident and can give meaning

to the definition of the concept. This includes mutual relationships, experience, knowledgeable and competency (Field 1991:25; Fulton 2015:42) at being a counsellor, facilitator, supervisor, advisor, assessor, teacher, as well as being trustworthy, a role model, and respectful (Al-Hamdan et al 2014:249; De Abreu & Interpeller 2015:45; Greenfield 2015:79). The mentor must also have clinical, teaching and interpersonal skills while motivating and promoting personal and professional growth (Peak & Kelly 2016:18; Goldie et al 2015:36). Other desired qualities of the mentor are commitment, giving feedback, honesty, providing support and sharing a common goal (Green & Jackson 2014:79; Vinales 2015:532). In spite of the various qualities of a mentor, it would seem unrealistic for all mentors to demonstrate all those attributes. Thus, mentors should develop those desirable qualities which students tend to expect from them. For instance, this would include good communicating and teaching skills, while being knowledgeable and nurturing a good relationship. To further understand the concept, Walker and Avant (2011:163) propose the construction of cases with all the defining attributes to clarify its meaning and the context. This includes a model case, a borderline case, a related case, and a contrary case.

2.4.3 Model case

Ram is a registered nurse who has completed his DGN and has seven years' experience as a qualified nurse. He is the recipient of the Leadership for Change Programme offered by the International Council of Nurses. As part of the programme requirements, he has to submit a project. He decides to seek guidance from Sounil, who is a charge nurse with whom he has worked during his training as a qualified nurse. Sounil has worked in various units for the past 25 years and holds a Degree in Nursing and a Post Graduate Degree in Management. He commands respect from all staff and is also a facilitator for continuing nursing education. Sounil supports and encourages Ram's initiative as this will further enhance his personal and professional growth. He promises his help, and both agree to collaborate and work together. Sounil also regularly meets with Ram to guide and teach him about how to write a project and assess its progress; he also gives feedback.

This model case illustrates the key attributes of a mentor. Thus, Ram trusted Sounil and they entered into a relationship. Sounil voluntarily accepted to commit himself to helping Ram. He shares his knowledge and experience through teaching and communicates regularly through meetings and feedback. This mentoring relationship promotes personal and professional development to achieve a common goal.

2.4.4 Constructing other cases

This involves constructing borderline, related and contrary cases. These cases may not contain all the attributes of a model case but help to ascertain which attributes are similar or contrary to select the appropriate one(Walker & Avant, 2011:164). A borderline case may contain most of the defining attributes but not all of them (Foley & Davis 2017:74; Hodgson & Scalan 2013:3). For example, from the model case described earlier, Sounil might not regularly attend to following up and providing feedback concerning the project, which can likely affect the relationship between Sounil and Ram in the long term. All the defining attributes may thus not be present in a related case (Olaolorunpo 2019:146).

There are related terms such as assessing, supervising, coaching and preceptoring. For instance, Rita,a first-year student, is assigned to a qualified nurse who will supervise her during her placement. Supervision alone does not involve teaching, evaluation, commitment, and neither favours personal nor professional growth. A contrary case will illustrate the negative attributes of mentoring (Olaolorunpo 2019:146). In this case, Anil is a second-year student and is working with Prem, a senior nurse. Anil is a keen learner and tells Prem that he will need his support when doing nursing procedures. Anil notices that Prem does not pay much attention to his request and draws his attention to this issue. The latter replies, “you have observed a lot of these cases, you should be able to do it and you know I am busy”. This is contrary to mentoring where no support is provided and neither there is a relationship.

2.4.5 Identifying antecedents and consequences

Antecedents are events or incidents that exist or have to happen before the occurrence of the concept, while consequences occur as a result of the concept (Walker & Avant 2011:167). For mentoring to take place, there must be experienced qualified nurses (mentors) and the presence of students (mentees) in clinical placement. A relationship must also be established between them for a common goal. Lack of mentoring can negatively impact on the personal and professional growth of students. Consequences are, in fact, outcomes of the concept. This mainly refers to the acquisition of skills and competencies by the students, the enhancement of personal and professional development of both mentors and mentees, the empowerment and motivation of students, reinforcement of practice standards, and the bridging of the theory-practice gap. Overall, mentoring benefits the students, the mentors, patients, and the organisation.

2.4.6 Empirical referents

Walker and Avant (2011:71) state that “empirical referents are classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself” which indicates that the concept has occurred. Empirical referents are generally associated with defining attributes from which the concept can be recognised or measured through observable occurrences (Walker & Avant 2011:168-169). Indeed, many tools have been developed and used to measure observable variables of mentoring. Among others, this includes the CLEI (Chan 2002; Ali et al 2015:4), the Mentorship Effectiveness Scale (MES) developed by the faculty mentoring committee of the Johns Hopkins University School of Nursing (Berk, Berg, Mortimer, Walton-Moss & Yeo 2005), and the CLESE (Choudhary et al 2014:11-15). These tools consist of different attributes and aspects of mentoring which can be empirically measured. However, given the subjective nature of mentoring the use and aim of these tools may vary accordingly (Hodgson & Scalan 2013:4). These tools are further examined in Chapter 3.

Drawing from the presented analysis, the following theoretical and operational definitions of mentoring within nursing are offered:

Theoretical definition: Mentoring is a shared formal relationship between an expert mentor and a mentee, where personal and professional growth is achieved through supervision, teaching, assessment, and engagement with each other. This takes place within the CLE.

Operational definition: Mentoring involves the support of students' learning in clinical settings. In this study, all aspects of mentoring are measured using a modified CLEI with relevant items, on a Likert-type scale. This was devised following Phase 1of the study.

Despite attempts being made to develop a comprehensive definition, there are still ongoing efforts to have a better understanding of the concept ‘mentoring’. As mentioned earlier, the recent decision from the NMC of the UK to replace traditional mentoring in the clinical settings with the introduction of “academic assessors”, “practice assessors” and “practice supervisors” indicates that the present mentoring system is not responding to the emerging needs of the profession. Furthermore, mentoring in nursing could likely be perceived as being complex and offering poor learning support for students, given that the UK mentoring system has always been considered a benchmark and the most cited in studies.

Further to the concept analysis, Fulton (2015:39-49) uses a different approach to examine the concept of mentoring, which focuses on the archaeology and genealogy of knowledge. The archaeology of knowledge is concerned with the historical background of discipline and how it influences practice over time, while genealogy of knowledge relates to power and the ways in which it is transmitted to others to improve practice (Fulton 2015:41-44). Fulton’s analysis reflects to a great extent how the practice of mentoring in nursing has evolved with time and its impact on the profession. The author

concluded that mentoring is a powerful tool that ensures the surveillance of both the students and the CLE. This new attribute adds a new dimension to mentoring.

2.5 THE CLINICAL LEARNING ENVIRONMENT (CLE)

Of all the mentioned factors, it is to be noted that mentoring takes place within clinical settings. Hence, all those factors are likely to impact on the practice placement of students. One key characteristic of practice placement is its CLE, which is a complex social entity that influences students' learning outcomes and experiences (Mokgele & Caka 2015:1263). To a great extent, the CLE influences the teaching and learning process of students in clinical settings (Jamshidi, Mozalem, Sharif, Torabizadeh & Kalyani 2016:1). The reasons for the CLE being complex are explained by the fact that nursing education dynamics have become complex in recent decades and within the CLE there is a network of forces (Lee et al 2018:103).

The clinical placement of student nurses is generally accepted as being central to nursing education since the practice training covers at least fifty percent of all nursing programmes. Practice placement should, therefore, be considered as an important 'corridor', which all students have to go through to qualify for their fitness to practice. Contrary to simulations performed in skills laboratories at school, the CLE provides students with real-life situations to use their cognitive, psychomotor and affective skills (Buthelezi, Fakude, Martin & Daniels 2015:1). A conducive CLE is critical for successful students' placement.

The term 'CLE' is often used when referring to clinical settings where work-based learning takes place. The focus is thus on skills acquisition, development of competencies and proficiencies of student nurses (Jacobsen & Hansen 2014:407; Vinales 2016:50). Therefore, the CLE is an entity in itself within the clinical setting which is subject to the constant changes of the healthcare environment. For instance, one innovative aspect which has been increasingly gaining popularity in the CLE is the use of e-mentoring. E-mentoring is also referred to as virtual mentoring which involves the

judicious use of the technological platform to support learning and for optimal outreach of students (Clement & Welch 2018:138). Virtual mentoring is an appropriate educational tool which allows various modes of communication for professional growth of mentors and mentees where ongoing contacts can be established as and when required (Clement 2018:1). While it saves time and is learner-centred, the mentor and mentee relationship could be unsecured in the long run if face-to-face contact is avoided (Walsh 2015:58). Exercising control of the CLE can also be challenging and stressful because of its unpredictable nature (Baraz et al 2015:52); it can positively or negatively influence the learning outcomes of students and the professional development of both nurses and students (Flott & Linden 2016:501).

Additionally, the CLE is more than pedagogical; it also has many dimensions and factors that are linked and intertwined with each other (Tomietto, Comparcini, Saarikoski, Simonetti & Cicolini 2014:43). The authors affirmed that these dimensions are linked to the organisational culture of the hospital, the ward climate, and the learning culture in place. These dimensions capture all aspects of the CLE that promote or affect the professional development of students and nurses from a broader perspective. In contrast, Hagg-Martinelle, Hult, Hendrickson and Kiessling (2014:15-23) point out that students should contribute to the development of the CLE. The authors also refer to the CLE as a “community of practice”, since members of a community share values, methods and goals for its flourishment.

While it is widely perceived that the CLE is exclusively limited to hospital settings, community settings can also be considered as an alternative to practice placements (Brynildsen, Bjork, Berntsen & Hestetun 2014:722-728). The authors argue that community settings include home care, nursing homes and mental health institutions. Despite these settings being different from hospitals, the policies and guidelines of caring tend to be the same. However, as health facilities are complementary to each other, it is likely that the coherence of ward climate, hospital and learning culture impact on the effectiveness of the CLE.

Nonetheless, a recent concept analysis undertaken by Flott and Linden (2016:501-513) provides a more concise picture of the CLE. The authors identified four attributes of the CLE which can impact on the learning experiences of students. These relate to physical space, psychosocial and interactions factors, organisational culture, and teaching and learning components.

2.5.1 The conducive clinical learning environment

Broadly speaking, the mentoring experiences of students and mentors tend to provide an overall view of the quality of the CLE. This helps in differentiating what makes a “bad CLE” or a “good CLE” (Brand 2016:2). Mokgele and Caka (2015:1-7) identified facilitative and obstructive factors associated to the CLE.The feeling of fear and anxiety, lack of consideration, being criticised and judged were perceived as being obstructive factors by students. However, being protective, valued and safe, creating good relationships, acceptances, being comfortable and empowered were seen as facilitating factors. Hence, managers, mentors and students must understand their proper roles and responsibilities for better mentoring outcomes rather than creating conflictual situations.

Likewise, Hagg-Martinelle et al (2014:22) suggest that management must ensure that planning, organising, and monitoring are in alignment to support CLEs. Similarly, Dimitriadou et al (2015:236) noted that students placed considerable value on the supervisory relation of the mentor, while the leadership style of the ward manager and the pedagogical atmosphere of the ward have been identified as influential factors for a conducive clinical environment (Papastavrou et al 2016:45).

Traditionally, the CLE environment has commonly been associated with the practice training of student nurses, but there are also students from other training programmes. This includes students from medicine, physiotherapy and occupational therapy who are likely to interact through learning from each other. Inter-professional collaboration contributes positively to students’ learning and professional identity (Jacobsen &

Hansen 2014:411). A key element of the CLE is the participation of students in their learning through teamwork, knowledge sharing and structuring of the learning outcomes while interacting with other health professionals in the CLE (Liljedahl, Boman, Bjork & Laksow 2015:284). Moreover, exposure to members of the multidisciplinary team provides a holistic view to caring and fosters a student-centred approach to learning (Houghton 2014:2368). Multidisciplinary teamwork and inter-professional collaboration are therefore key factors within the CLE which further enhance the skills and knowledge of both mentors and students. However, to maximise learning in the CLE other forms of support sustain mentoring.

2.5.2 Learning supports in clinical learning environment

According to the NMC (2008), practice educators are academic staff from the university who spends fifty percent of their time in the practice placement to oversee and assist both mentors and mentees while focusing on the assessment of clinical training. Hence, they form part of the learning support system. In one recent study conducted in a university in the UK, Maxwell, Sharon and Baillie (2015:35) stressed the importance of practice educators. Their study adopted a qualitative approach known as appreciative inquiry, which is a philosophy and method based on a participatory approach to facilitate workforce engagement, promoting organisational learning and positive organisational change in the healthcare context (Trajkovski, Schmied, Vickers & Jackson 2013:95). Their sample consisted of practice educators (n=10), nursing students (n=5) and mentors (n=3). The purpose was to gather diverse views from all individuals to foster learning and promote innovative ideas. The study was conducted in three phases; data were firstly collected through semi-structured interviews, then a modified Delphi technique was used for the second phase. Thereafter, two consensus workshops were held to agree on the roles and principles of practice for practice educators.

Their findings underscore the special roles of practice educators who were identified as being the bridge between academia and clinical settings. The presence of practice educators in the ward further reinforces social processes since they are always

available, while they also assist both the mentors and student nurses in decision making and critical thinking to ensure safe practice (Maxwell et al 2015:43). The authors concluded that practice educators are critical to sustaining academic/practice partnership and promoting evidence-based practice.

The same view is also shared by LeFlore and Thomas (2016:187), who stated that the simulation and academic-practice partnership model could offer innovative approaches to the training and education of nurses for the provision of safe and quality care. This model of supporting learning in clinical practice seems appropriate as it addresses mentoring in the CLE from a broader perspective and also attempts to close the theory-practice gap in the real sense. In contrast, a different view is offered on the roles of mentors and link lecturers in the UK (Foster et al 2015:18). Link lecturers ensure the liaison between the training institution, the CLE and the management. The authors reported that both mentors and link lecturers were not perceived as being of high importance to mentoring. Instead, the students were of the view that their learning support needs are strengthened by the university. This likely points to the engagement of practice educators as an effective and alternative means of providing learning support, as mentioned earlier. The findings of the studies therefore indicate that the support of academic staff can greatly contribute to quality mentoring.

In addition to the appreciative inquiry approach, mentoring has also been explored through integrative reviews. This approach usually draws from extensive primary sources with consistency in the study design, along with the use of diverse methodologies (Phillips & Merill 2015:116; Whittemore & Knalf 2005:547). Jokelainen (2013:1-62) used an integrated approach through systematic qualitative review to explore the elements of effective mentoring in CLE. This was then followed by focus group interviews with British and Finish mentors. Both findings were synthesised and conceptualised into a framework known as SMiLE-iN (Student Mentorship in Learning Environment in Nursing). The elements central to the framework included organisational, environmental, collegial and personal capacities (Jokelainen 2013:42). These were further associated with a range of key factors such as the facilitation of

students' learning, strengthening students' professionalism, financial investment, managers engagement as capacity builders to mentoring of students and mentors pedagogical proficiency. However, the author recommended that the framework needs to be tested and developed further.

Besides, peer learning is also considered as learning support in the CLE. Stenberg and Carlson (2015:48-55) explored the perception of Swedish student nurses on peer learning as an educational model. It was found that the peer learning model brings a sense of competition, a feeling of safety, and good learning experiences. Nonetheless, the peer education model can also lead to negative experiences, such as students not fully being prepared to teach, and the unwillingness of students to collaborate owing to incompatibility and competition with each other (Stenberg & Carlson 2015:53). In general, learning support is offered to ensure that students' learning outcomes are met, but more importantly, the theory-practice gap is addressed as well.

2.5.3 The theory-practice gap in the clinical learning environment

The term 'theory-practice gap' may be differently defined, but it simply refers to the discrepancy between the theoretical knowledge gained in the classroom and the students' learning experience in the CLE. Mentors must ensure that theory learned at schools by students are integrated into practice, as this sustains quality, drives best nursing practice and contributes to reducing the theory-practice gap (Zenani 2016:2). The theory-practice gap in the CLE has been recognised as a global concern and remains a challenging issue as nursing education is increasingly shifting to universities (Waweru, Mapesa & Elijah 2016:99). Within the literature, there is a clear gap between what is taught at school and what the students experience in wards (Saifan, Aburuz & Masa'deh 2015:20). El Hussein and Osuji (2017:22) argue that the theory-practice gap within nursing has existed for a long time, owing to the absence of a clear definition of nursing knowledge. The authors further point out that knowledge generated by researchers is often not applied in clinical settings. In fact, the CLE is nurse-led and nurses tend to make deductive reasoning out of theoretical knowledge. Although

learning support in the CLE seeks to reduce the theory-practice gap, it does not adequately address the problem (El Hussein & Osuji 2017:24). In response, the authors suggest that the application of new knowledge should be an ongoing process by promoting reflection, critical thinking and evidence-based practice. Likewise, Cunningham, Baird and Wright (2015:265) refer to the term 'spiral theory-practice gap' to substitute 'theory-practice gap'. The authors explained that this would require mentors to realign the integration of theory into practice as an iterative process and in parallel engage in reflection with experiential learning and role modelling.

In general, most students attempt to integrate theory into practice with the help of their mentors, and at times, on their own. Theories are considered to be abstract in nature and students are often forced to apply their theoretical knowledge in the CLE just to conform to ward policies and their mentors (Athistam & Jacoline 2015:443). Such situations in unconducive CLEs become barriers and tend to widen the theory-practice gap. Hence, it is important to identify the barriers and devise strategies to address the theory-practice gap in the CLE in an effective way.

There are common barriers to bridging the theory-practice gap, including inadequate support structures, poor communication and feedback, inexperienced mentors without qualification, poor knowledge of curriculum design and teaching methods, and the absence of collaboration between educators and the CLE (El Hussein & Osuji 2017:23; Saifan et al 2015:24; Waweru, et al. 2016:99, Zenani, 2016). Cunningham, Baird and Wright (2015:265) recommend the following approaches in addressing the theory-practice gap:

- Clinical simulation under a real situation
- Skills lab and role play
- Reflective diaries, journals and practice
- Class and task-based learning with arange of learning resources
- Qualified clinical instructors who are conversant with pedagogy
- Partnership between school and clinical settings

Even when learning support is provided and the theory-practice gap is addressed, the way teaching and learning are conducted in the CLE is instrumental in successful learning outcomes.

2.5.4 Teaching and learning in the clinical learning environment

In principle, learning support in the CLE is associated with the teaching and learning of students, along with offering patient care. Hence, it is crucial for mentors to be conversant with the teaching methods, the learning style of students and the types of assessments used in clinical settings. These variables also influence students' ability to apply theory to practice in an effective way. It is argued that learning within the CLE does not take place unless the students have been equipped with the necessary attitude, skills and knowledge. One way of maximising learning support for students in clinical settings in terms of skill acquisition and knowledge development is through the application of learning theories (McInerney & Green-Thompson 2018:900). Common learning theories fall within three categories with distinct philosophies, namely the behavioural, cognitive and the humanist (Aliakbari et al 2015:2). Arguably, any theory has its strength or weakness, and at times is incomplete without each other. Hence, a combination of approaches can be used, depending on the context. The humanist approach, for instance, favours the principles of adult learning and focuses on student-mentor relationships, thereby contributing to the openness and professional growth of the students (Aliakbari et al 2015:9).

The importance of experiential and adult learning in clinical practice has been highlighted by Sand, Elison-Bowers, Wing and Kendrick (2015:1-7), while Sinnerton, Leonard and Rogers (2015:1-5) have stressed the relevance of Kolb's learning cycle which is mostly applied to practice. The principles of adult learning draw from Knowles' (1973) theory of learning which postulates that adults are motivated and self-directed. They have knowledge and experiences, are goal orientated and practical, and value mutual respect (Aliakbari et al 2015:9). At the one end, Knowles' theory also has a

humanist approach where students are allowed to participate actively in their learning process as opposed to didactic learning. Sinnerston et al (2015:2) emphasise that the very foundation underpinning Kolb's (1984) learning theory is based on experiential learning, which in itself is a process where knowledge is generated through the transformation of experience. This process encompasses four phases which overlap each other (Mohammadi & Thaghinejad 2014:2; Sinnerton et al 2015:2).

- ***Diverging*** - a learning style where the learner prefers to observe and have a concrete experience.
- ***Assimilating*** - the learner starts reflecting and reviewing what has been observed.
- ***Converging*** - the learner makes abstract conceptualisation and engages in logical reasoning to conclude on the experience.
- ***Accommodating*** - the learner attempts to put into practice what he has learned.

The application of Kolb's experiential learning in the CLE can better contribute to understanding and shaping the students' learning styles while effectively meeting their learning needs. Moreover, it involves the students in reflective practice, critical thinking and motivates them to be independent. Experiential education can be a preferred method for effectively teaching adult learners in clinical healthcare programmes (Sand et al 2015:2). Kolb's learning theory differs from others and is widely used in education since it draws from a set of comprehensive learning theories (Mohammadi & Thaghinejad 2014:5). This approach to experiential learning is also aligned to Benner's theory, from novice to expert as described in Chapter 1.

Promoting experiential and self-directed learning in the CLE are key strategies in facilitating the integration of learning into practice and the overall improvement of students' outcomes (Sinnerton et al 2015:4), while feedback remains crucial in ensuring the best use of the contact time. As adult learners, it is to be acknowledged that the professional growth of students will evolve when mentors value the learning styles of each student. However, to ascertain that teaching and learning have taken place it has to be evaluated through an assessment.

2.5.5 Assessment in the clinical learning environment

Within the realm of assessment related to training and education, there are two types of assessments. This includes the summative assessment, which evaluates the theoretical aspects and the formative one, which focuses on the practical component. The clinical evaluation of student nurses has been the subject of much debate and the contentious issue has been revolving around subjectivity (Rafiee, Moattari, Nikbakht, Kojuri & Mousavinasab 2014:50). In a systematic review using both qualitative and quantitative studies, Helminen, Coco, Johnson, Turunen and Tossavainen (2016:308) confirm the lack of consistency in students' assessment processes, which is open to the subjective bias of the assessor. An explanation is that not all assessors think alike, decide and apply the same judgment when it comes to evaluation.

Maintaining quality assessments of students and giving feedback in clinical settings remain a challenge for mentors owing to the constant changes within the healthcare environment (Baumgartner, Stahl, Manninen & Hardman 2017:112). With regards to nursing, both forms of assessments are conducted and formative assessment is directly linked to the CLE, which is often referred to clinical assessment. Overall, clinical assessment tends to measure competence and encompasses knowledge, skills, and attitude.

Rafiee et al (2014:41-49) reported on some factors that affect the clinical assessment. Both students and clinical instructors found that clinical evaluation methods and processes were inappropriate, clinical training programmes were not properly structured, and clinical assessment was not conforming to any guidelines owing to a lack of regulations. Moreover, differences in clinical evaluation, deviation from learning objectives and outcomes, overlooking relevancy of clinical topics, workload and lack of experiences were identified as weaknesses of clinical instructors by the students. Nonetheless, poor attention and lack of knowledge regarding learning outcomes from the part of the mentors have a direct impact on the trustworthiness of the assessment (Sand et al 2015:3).

Constraints that affect assessment include lack of supervision and openness, duration of the placement, the student population, and failure to update knowledge (Sand et al 2015:5). It has also been found that mentors have difficulties with practice assessment documents and practice teachers are in a better position to conduct a final assessment (Helminen, Tossavainen & Turunen 2014:1161-1166). These findings are in line with those highlighted in the systematic review of Helminen et al (2016:308). Indeed, mentors' roles are new and they often lack experience and are not prepared to effectively assess students in clinical practice (Bennett & McGowan 2014:454). Moreover, if incompetent pre-registered students are allowed to pass, they will eventually gain entry to the register and might pose a potential risk to patients' care and safety at some point (Sand et al 2015:5). The outcomes of these studies support the fact that those taking the role of assessors must be competent and conversant with both summative and formative assessments.

Assessment becomes even more challenging and stressful when mentors or educators have to decide whether to fail or pass under-performers as it remains a difficult process (DeBrew & Lewallen 2014:631-636; Luhanga, Larocque, McEwan, Gwekwerere & Danyluck 2014:1-26). Mentors are reluctant to fail students for various reasons. This includes lack of academic and emotional support for both mentors and students, consequences that might arise in terms of the image of the institution, and at times the struggle can be based on personal, professional and structural reasons (Luhanga et al 2014:1). The authors recommend that the quality of practice placement should be improved and support should be provided to faculty members and students regarding the failure of students.

Alternatively, DeBrew and Lewallen (2014:633) suggest the use of the critical incident technique to manage poor performers. This technique requires students to reflect on their meaningful experiences and choose the more significant one. Its reflective nature allows students to recall situations and events which did not work or worked during their training to solve a practical problem. Mentors and educators will, therefore, need to consider the various assessment options to provide optimal support to poor performers.

Within the literature, one framework which has been commonly referred to is the seminal work of Miller (1990:63), who proposed a framework for a clinical assessment for health professionals as shown in Figure 2.1.

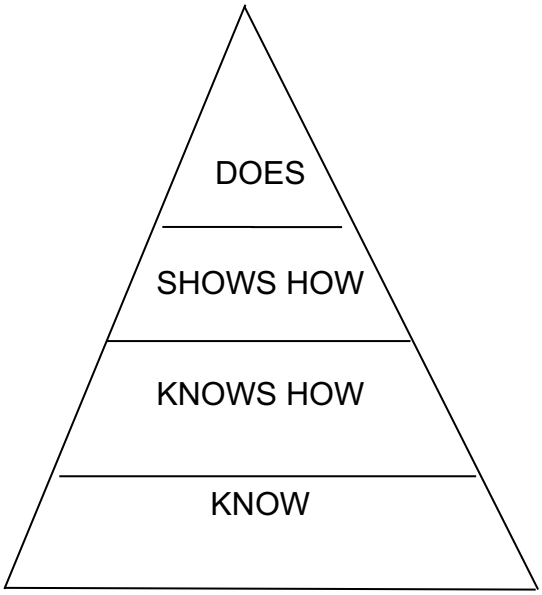

Figure 2.1: Miller's Assessment framework

Adapted from Miller's framework (1990) for clinical assessment

At the base of the pyramid lies knowledge (knows), then competence (knows how), performance (shows how) and action (does). Knowledge gained is usually tested through written examination, which is then applied into practice to assess competence like testing clinical skills. Performance and action are based on observation and work-based assessment demonstrated through the ability to manage cases and solve a problem (Miller 1990:65). This pyramid also shows how students' knowledge is translated into action, thus reflecting Benner's work from novice to expert. Furthermore, it also tests the essence of learning; that is, knowledge, skills, and attitudes. Miller (1990:65) also highlights the importance of objective structured clinical examination (OSCE) as a new format of assessment, which involves a range of assessment techniques from multiple-choice questions to simulations and case scenarios. As such,

OSCE appears to be a comprehensive method to be considered for assessing students since it incorporates both summative and formative components of an assessment. However, since assessment appears to be a complicated process, a wrong decision on the part of the mentor could have serious consequences on the fitness and purpose of practice of the student (Brand 2016:5).

Finally, an assessment should, therefore, measure competence validly and reliably to ensure that pre-registration students are fit to practice (Cunningham et al 2015:266). To ensure consistent and reliable assessments, Rafiee et al (2014:49) suggest that objective clinical evaluation can be achieved with new methods and new tools. Hence, strategies need to be developed regarding the assessment criteria and learning goals for a better understanding and use of the assessment tool (Baumgartner et al 2017:121). Equally important is feedback on the assessment, which reinforces the confidence, motivation, and self-esteem of the students. The role of the CLE is not limited to the clinical training of students but has implications beyond this mission. It remains the crossroads to which students have to be exposed for their professional growth. It provides students opportunities to experience nursing in its 'real world', as Greenfield (2015:1) puts it. Knowledge and insights of the CLE are thus critical to mentors because of its complexity.

A scanning or deep insight of the CLE tends to portray it as an organisation which is influenced by internal and external forces along with a multitude of factors. It can be argued that the CLE functions like an ecosystem; any changes from within or outside will affect and impact on students' clinical placement and their learning. Stated otherwise, the internal and external forces should be in harmony with each other for a conducive and effective CLE.

The literature on CLEs indicates that mentoring students requires a good learning climate in the ward, along with its learning culture. Nurturing the mentoring relationship is critical to sustaining the learning support of student nurses in the CLE. The management of the CLE, knowledge of pedagogy and teaching remains key pre-

requisites for the mentor to function effectively to better respond to the learning needs of the students.

2.6 SUMMARY

This chapter has reviewed the literature concerning mentoring and how it has evolved to date. The sources reviewed draw mainly from European and Western countries as articles from African, Asian and Middle East countries were sparse. The mentoring system from the UK has been cited frequently in many studies. The review has highlighted the various aspects of mentoring and how it is deeply rooted in nursing education. The synthesis of the findings and conclusions from discussion papers using Walker and Avant's (2011) method has unfolded the desired attributes of mentors within a complex and challenging health system.

Most of the studies reviewed have been largely from students' perspective and some from both students' and mentors' viewpoints using qualitative approaches. A few studies included quantitative, systematic reviews and convergent parallel mixed methods. However, the focus of all the studies revolved principally on factors influencing mentoring and the clinical environment. Yet, the outcomes of these studies and those from the literature do not point towards any clinical mentoring framework despite international differences regarding the practice of mentoring and its definitions. Furthermore, no study was found within the literature that used the exploratory sequential mixed method, neither has mentoring been investigated as a researchable phenomenon in Mauritius among student nurses and nurses. This study, therefore, sought to address this gap by developing a contextually relevant clinical mentoring framework for student nurses in Mauritius to enhance the standard of student nurses' training during clinical placements.

The next chapter will describe the research design and methodology.

CHAPTER 3
RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

This chapter outlines the research design and methods of this study, which encompass the key elements of the research process, and describes the various steps of the process undertaken. This includes the aim and objectives, the choice of the design, the population and the sample, data collection, data analysis, validity and reliability, and ethical considerations. An exploratory sequential mixed method was used for the study. The method will be discussed under two phases as data were collected in a two-phase approach. A qualitative approach was used to collect data in the first phase, and thereafter a structured questionnaire was used to collect data for the quantitative phase.

3.2 RESEARCH OBJECTIVES

The research objectives for both phases were as follows:

Phase 1 – Qualitative

- To explore and describe the experiences of qualified nurses regarding current clinical mentoring practices.

Phase 2 – Quantitative

- To investigate the current clinical mentoring practices from both qualified nurses' and students 'perspectives.
- To compare the current clinical mentoring practices as perceived by qualified nurses and students.

- To determine whether the current clinical mentoring system responds to the practice learning needs of the DGN Programme.

3.3 RESEARCH DESIGN

A research design usually involves the planning of a study which guides its implementation to achieve the intended outcomes (Grove et al 2015:511). The research design is greatly influenced by the nature of the researchable problem and its anticipated outcomes. Within the conduct of a study, the research design provides specific direction with regards to the various steps that need to be followed in addressing the research problem (Cresswell & Cresswell 2018:11). For the purpose of this study, an exploratory, sequential mixed method was used; that is, a combination of both qualitative and quantitative approaches (Halcomb & Hickman 2015:41). The design was descriptive and exploratory.

3.3.1 The mixed methods design

In general, the description can be the main purpose of a qualitative or quantitative study. The terms ‘descriptive’ and ‘exploratory’ designs are often used interchangeably or alone to describe a study. Descriptive studies attempt to provide an exact picture of a group in real-life situations to discover new meanings and describe exactly what exists(Grove et al 2015:518), while exploratory studies attempt to provide new insight and ideas in order to understand the full nature of a phenomenon in real situations about which little is known (Manerikar & Manerikar 2014:95). In this study, the mixed method adopted a descriptive exploratory cross-sectional design to describe a situation which has not previously been explored and described in the local context. A cross-sectional design is commonly used to gather information on a phenomenon at one point in time (Leavy 2017:288). The phenomenon for this study related to clinical mentoring and was investigated within a specific context, namely the regional hospitals in Mauritius. Thus, the primary aim of descriptive research is to plan and gather facts to describe and explain characteristics or functions of a group regarding the phenomenon

under study, while the purpose of an exploratory design is to gain insights on a phenomenon through ideas, thoughts, and experiences. Most quantitative studies are associated with descriptive designs, while exploratory designs guide mainly qualitative studies.

3.3.2 Mixed methods

Two main approaches are widely used to conduct research. These are the structured approach, also referred to as quantitative methods, and the unstructured approach, known as qualitative methods (Cresswell & Cresswell 2018:3). Both approaches apply scientific methods and have different philosophies. The underlying philosophy of the quantitative method is rooted in positivism, which assumes that phenomena can be measured using deductive principles of scientific methods (Bowling 2014:132), while the philosophy underpinning qualitative research is based on interpretivism, that is, how people give meaning to their daily interactions (Leavy 2017:262). This philosophical view posits that a phenomenon, situation or problem can only be understood through description, perception or lived experiences, and the subjective interpretation given by all those involved in the study within its social context.

The combination or integration of both qualitative and quantitative data within mixed methods provides a better interpretation of the analysed data through a common meaning (Denscombe 2014:13). Arguably, mixed methods will have the characteristics of both qualitative and quantitative methods. Over the past decades, mixed methods research has emerged as an alternative approach because of its increasing use and the growing interest shown by researchers (Cresswell & Cresswell 2018:292). Despite the predominance of quantitative and qualitative methods in the field of research, mixed methods form part of another school of thoughts that is considered as the third paradigm (Doorenbos 2014:207). It provides different perspectives to researchers for investigating and understanding a phenomenon comprehensively, rather than using either a qualitative or quantitative approach alone (Halcomb & Hickman 2015:15). Moreover, it further helps in gaining deeper insights into a phenomenon from broader

angles (Bowling 2014:419), while its worldview is based on real situations and consequences rather than antecedents (Cresswell & Cresswell 2018:11).

3.3.2.1 Pragmatism as a foundation of mixed methods

Although pragmatism is based on both interpretivism and positivism, it is not associated with any system or philosophy (Rahi 2017:1). Its foundation lies on 'complementarity', whereby one approach enhances each other to provide a better strategy to answer the researchable problem (Shannon-Baker 2016:325). In using mixed methods, researchers tend to challenge the traditional post positivists' and naturalists' modes of inquiry. Thus, the notion of pragmatism within mixed methods implies that researchers should not only judge the appropriateness of paradigms, but rather which one will be more useful in exploring and understanding the phenomena (Durand & Tracey 2014:148). The authors further argue that the use of a single approach does not provide a complete picture of a researchable problem, thus using the mixed method is more pragmatic. In practice, mixed methods, therefore, focus on a single study to investigate a phenomenon using different methods to ensure that there are fewer or no gaps in the information collected (Ingham-Broomfield 2016:50). Likewise, proponents of pragmatism believe that true knowledge can only be generated through mixed approaches as it tends to adopt both a subjective and objective stand (Shannon-Baker 2017:322). Pragmatism, therefore, allows the researcher to choose an alternative which can better provide in-depth information on a phenomenon, rather than using either the traditional qualitative or quantitative method alone.

3.3.3 The mixed methods design

There has been increasingly greater use of both quantitative and qualitative methods within the same study. However, since these two paradigms have diametrical views with incompatibilities, it has led to the emerging of a more balanced pragmatic paradigm known as mixed methods that offset the clashes that have existed between paradigms (Bowling 2014:365). Cresswell and Cresswell (2018:294) identified three types of

designs associated with mixed methods. These are the convergent parallel, the explanatory sequential, and the exploratory sequential mixed methods designs.

3.3.3.1 Convergent parallel mixed methods

In this design, both qualitative and quantitative data are collected concurrently and analysed separately. Both forms of data are collected using parallel variables. The findings are then compared to ascertain the extent to which they are similar or dissimilar.

3.3.3.2 Explanatory sequential mixed methods

This design involves the collection of quantitative and qualitative data in phases. Firstly, quantitative data are collected and analysed. The results are then used to build on the second phase; like the types of questions to be included in the interview schedule or the sample size.

3.3.3.3 Exploratory sequential mixed methods

This design is the opposite of the explanatory sequential method. It starts with the qualitative phase, where data are collected and analysed to inform the quantitative phase. This strategy helps to design better measurement instruments and allows seeing or testing whether the data can be generalised to a larger sample population. This can be generally regarded as a three-phase procedure, with the first step being exploratory, the second being the design of the instrument, and the third the administration of the questionnaire to a larger sample population.

3.3.4 The choice of the design

In this study, a descriptive exploratory sequential mixed-method design was used. The rationale for choosing this design was based on the theoretical stance of the researcher

which draws from two philosophical assumptions known as ontology and epistemology. Ontology refers to our assumptions about how we see the world, while epistemology deals with the nature of knowledge and knowing; that is, what is the best way of studying the world (Leavy 2017:12). The choice of mixed methods revolves around three principles and the advantages and disadvantages of mixed methods also impact on the choice of the researcher.

Firstly at a general level, because of its inherent strengths that tend to limit its weakness, secondly at a procedural level, it provides the researcher with an alternative method to better study a phenomenon, and thirdly at a procedural level it attempts to give an overall picture of the researchable problem (Cresswell & Cresswell 2018:303). The choice of a descriptive exploratory mixed-method design for this study was deemed suitable since it was in line with the aim of the study. This approach helped to gain both subjective and objective responses regarding mentorship and provided rich contextual data on a topic which had never been studied in the local context.

3.3.4.1 The advantages of mixed methods design

As a relatively new approach, mixed methods provide an alternative means to view phenomena from a different perspective and build on the strengths of both quantitative and qualitative methods to limit its weaknesses (Halcomb & Hickman 2015:42). Thus, the accuracy of the findings is improved and enhanced, which add credibility to the study (Denscombe 2014:140). In mixed-method designs, two approaches are used and data are collected from at least two sources that are then integrated into the study. This is also referred to as methodological and data triangulation (Leavy 2017:170). Furthermore, triangulation facilitates the development of instruments and attempts to maximise the validity of findings (Durand & Tracey 2014:168). Mixed methods are also problem-driven rather than theory-driven and allow corroboration of findings; in fact, both approaches are complementary (Halcomb & Hickman 2015:45).

Nonetheless, the use of mixed methods requires the researcher to be familiar and conversant with both qualitative and quantitative methods. In contrast, the data collection from two methods, its analysis and integration in the study, along with a combination of inductive and deductive reasoning, poses a real challenge to the researcher (Leavy 2017:186). The management of the data in itself, the resources required and the time invested by the researcher for the whole process is perceived as a setback for mixed methods (Cresswell & Cresswell 2018:293). Moreover, proponents of quantitative and qualitative methods who believe in the rigidity of the deductive and inductive approaches argue that mixed methods are 'invalid' and 'contradictory' (Bowling 2014:420). In spite of these setbacks, the researcher believed that the design was still worthwhile, as it would provide better insights through its triangulation methods in response to an unexplored phenomenon in the local context. In this study, the researcher was assisted by a graduate colleague during data collection in Phase 1. The progress and outcomes of Phase 1were closely monitored, reviewed and cross-checked in a stepwise and timely manner by the promotor.

3.4 STUDY PHASES

Further to the background of the study design, the sections that follow will describe the phases involved in the mixed methods used in the study. Data in the first phase were gathered using a qualitative approach. Semi-structured interviews were conducted with qualified nurses who acted as mentors. The data were analysed, and the findings were subsequently used for the development of the data collection tool in the quantitative phase. Data were then collected using a self-administered questionnaire presented to both qualified nurses and students nurses. The methods used for the two phases will be discussed separately for the sake of clarity.In the final phase, the findings were synthesised using Dickoff et al's (1968) survey list to develop the clinical mentoring framework for student nurses.

3.5 PHASE 1: QUALITATIVE PHASE

In principle, qualitative research tends to explore, understand, interpret and give meaning to a phenomenon under study as experienced and lived by participants in their natural settings (Grove et al 2015:67). This phase of the study draws mainly from an interpretive approach as it seeks to analyse how people give meaning to a phenomenon within their social world. In this study, the views and responses expressed by participants on the phenomenon under study were from their subjective viewpoints. Qualitative research produces descriptive data which is non-numerical and does not require statistical analysis as the responses are either written or spoken words from participants (Cresswell & Cresswell 2018:244). Qualitative researchers tend to avoid assumptions and are not pre-judgemental as they acknowledge that people's interpretations of a phenomenon or situation vary from one another (Bowling 2014:364).

Qualitative methods provide better insights on a phenomenon by answering 'why', 'what' and 'how' an issue is perceived, particularly when is little understood about it (McCusker & Gunaydin 2015:537). Thus, this approach allowed the researcher to explore the phenomenon in terms of how people make sense of it in their real world, which is basically associated with multiple aspects (Rahman 2017:103). Little was known about the practice of mentoring by nurses in the local context. A qualitative design was therefore chosen for this phase. The choice of this approach for this phase of the study was deemed appropriate since the researcher sought to explore and describe the mentoring experiences of nurses within the CLE.

3.5.1 The population

The population refers to all members having at least one common attribute of interest to the researcher which qualify them to participate in a study (Asiamah, Mensah & Oteng-Abaye 2017:1611; Grove et al 2015:525). In other words, it consists of the largest group of participants available to form part of the study, commonly determined according to the aim and objectives of a study. According to the register of the CSN, the population

for this phase of the study was all qualified nurses (N=996), working within the five regional hospitals across the island. The researcher identified the target group from the general population from which the accessible population was drawn; that is, those who participated in the study. The target population is chosen according to selection criteria based on specific characteristics which the participants possess, while the accessible population refers to those participants from the target group who are willing to participate and available for the study (Asiamah et al 2017:1611).

3.5.2 The sample

A sample is a subset of the population eligible to participate in a study, and sampling refers to techniques used to select the sample (Leavy 2017:287; Grove et al 2015:527). In its broadest sense with regards to the qualitative approach, it is the selection of data sources from which the research objectives can be addressed. It is the inclusion of participants who conform to the selection criteria of the study (Gentles, Charles, Ploeg & McKibbon 2015:1775). In qualitative methods, there is no pre-determined sample size as compared to quantitative methods, but the sample size is dependent partly on the design and the context under which the study is taking place (Boddy 2016:426). As such, there are no hard and fast rules when determining the sample size for qualitative studies, but qualitative researchers need to justify their decision regarding sample size (Boddy 2016:427). The author further argues that once data saturation is reached, the sample size can be decided. Data saturation refers to the point at which there is redundancy of information which serves little or no use for the study (Gentles et al 2015:1781). In the same vein, Bowling (2014:396) argues that the sample size in a qualitative study is a challenge as there is no clear guideline for an appropriate cut off point.

A small sample is also referred to as an exploratory sample and is generally used to gather qualitative data on unexplored topics for small scale research which allows probing and provide rich information (Denscombe 2014:43). Moreover, qualitative research usually uses a small non-random sample with a small sample size (Cresswell

& Cresswell 2018:253). In this study, non-probability sampling was used so participants were not chosen randomly. A purposive sample was preferred, where the participants were handpicked by the researcher because of their relevance and knowledge of the phenomenon under study (Denscombe 2014:50; Gentles et al 2015:1778). This ensured that accurate and reliable information was gathered from the thoughts and experiences of the participants. Samplings in qualitative studies are not about representativeness; rather, it is concerned with the appropriateness (relevance) and the size of the sample (extensiveness) (Gentles et al 2015:1781; Guetterman 2015:17). The choice and the size of the sample for this phase were based on these two elements.

The participants in this study were nurses with an average of 20 years' experiences. Participants were chosen from the five regional hospitals to make a sample size of eight (n=8), following data saturation. Saturation was achieved after the sixth interview. Two additional interviews were conducted to confirm the saturation. The following criteria were applied for participants forming part of the study.

3.5.2.1 Inclusion criteria

- Qualified male and female nurses working in regional hospitals.
- With at least 15 years' post-qualification experiences.
- Having completed their Top-up DGN.
- Posted in clinical settings where students are on clinical placement.

3.5.2.2 Exclusion criteria

- Nurses who completed their Top-up Diploma in Nursing and were on the eve of their retirement were excluded from the study, since they were already on pre-retirement leave and were not serving in hospitals.
- Those who have already retired were excluded as well.

3.5.3 Data collection

Data were collected using face-to-face semi-structured interviews and included field notes. The semi-structured approach to an interview is the preferred method of data collection in qualitative studies (Alshenqeeti 2014:40; Grove et al 2015:83). It uses a blend of closed and open-ended questions along with follow-up questions to gather in-depth information (Adhabi & Anozie 2017:87). In qualitative studies, a large amount of data is generated mainly through field notes, which may include interview notes, transcripts, memos, observations and analysis (Leavy 2017:137).

Semi-structured interviews are flexible as the researcher avoids being too rigid or open by attempting to uncover substantial information from the interviewee (Grove et al 2015:83; Zohrabi 2014:256). This method allows the interviewer some degree of flexibility that they can probe fully to obtain detailed information, clarify any ambiguities and check for inconsistencies and misinterpretations (Leavy 2017:140; Denscombe 2014:176).

The disadvantages of face-to-face interviews are that it is expensive and the involvement of the researcher and their interaction with the participants in the data collection process can be a source of potential bias. This can likely influence the outcomes of the study. Moreover, face-to-face interviews are time-consuming, and the personal engagement and commitment of the researcher in data collection and analysis can pose a threat to the credibility of the findings (Grove et al 2015:83; Bowling 2014:279). Also, readers tend to question the rigour of the approach with regards to the value of the study in terms of objectivity, accuracy, trust and the researcher's ascribed meaning to the findings (Alshenqeeti 2014:40). To reduce the risk of bias, the researcher avoided being pre-judgemental by bracketing his beliefs, values, and knowledge on the phenomenon under investigation (Grove et al 2015:501; Denscombe 2014:180). Furthermore, the participants were not being guided or influenced by the researcher in answering their questions to maintain objectivity and neutrality.

Open-ended questions are commonly used during interviews to allow the interviewees to freely express their views to elicit maximum information on the phenomenon (Leavy 2017:138; Denscombe 2014:176). Data were collected by the researcher after ethical clearance and permission were obtained from respective authorities (Annexures A, B & C). The researcher firstly contacted the participants in the hospitals where they were posted. A meeting was then arranged to brief them about the nature of the study and to ask whether they would voluntary participate in the study. They were also informed that the interviews would be audio-recorded. This helped in establishing rapport with them and was done formally. Those who accepted to participate were invited to sign a consent form, which also provided relevant information regarding the study (Annexure D). Thereafter, they were contacted again to arrange a convenient day and time for the interviews. In qualitative studies, the researcher gathers data in the natural settings where the participants experience the phenomenon, and the researcher remains the key data gathering instrument while interacting with the participants during the interviews (Cresswell & Cresswell 2018:254; Bowling 2014:202). All interviews were conducted the hospitals in the ward managers' office and the researcher was accompanied by a graduate colleague who assisted in taking notes and maintaining all documents. Arrangements were made with the ward managers to prohibit access to their offices during the interview sessions. The purpose was to avoid distracting the participants, and the researcher was thereby able to maintain the privacy of the interview process.

An interview guide (Annexure E) with semi-structured questions was used to collect data through face-to-face interviews. Initially, the interview guide was designed with minor changes following the scrutiny of the promoter. Two questions were rephrased, and two were omitted. Thus, six questions appeared on the interview guide. Before the collection of data, the interview guide was pre-tested with two nurses through a pilot study. A pre-tested instrument helps to assess the quality of the tool so that it can be modified to obtain valid, unbiased and reasonable responses during the interview (Grove et al 2015:45). The purpose of a pilot interview is to ascertain the possible

difficulties which both the interviewer and the participants might encounter during the interview process as it is a trial run of the full scale of the study (Cope 2014:696).

The interviews started with general questions such as “How was your day?” to build trust and make the participants comfortable for the interview. The review of the first two interviews indicated that the participants were straightforward and short in their answers as detailed information on the phenomenon did not emerge. In response to this, they were further interviewed on certain aspects through facilitative techniques. Koskei and Simiyu (2015:110) suggest the use of probes and prompts to go deeper in a given situation. Probes are used to assist the participant to say more on a topic by either clarifying or elaborating on it. An example of a clarifying probe used in the study is; “*You have said assess; can you tell me how it is done?*” An elaborating probe was “*You say the needs of the students and mentors; could you please elaborate?”* Prompts are used to gather information which the participant failed to mention during an interview. An example of a prompt used in the study was *“Do you think there are other factors than what you have mentioned?”* The interviews were audio-recorded and lasted for 25-30 minutes with a total of eight interviews. As the interviews progressed, it was noted that at a certain point no new information was emerging, indicating that data saturation was reached.

The use of an audio-recorder (with permission from the participants), along with taking field notes ensures that comprehensive data are captured during face-to-face interviews (Bowling 2014:140; Denscombe2014:183). Field notes help in jotting down key issues during the interview and nonverbal communication, while the audio-recorder serves as a complete permanent record for further confirmation and reference. The researcher also kept a reflective diary during the study, where all daily activities and important events were recorded. This included personal ideas, views, and other observations such as participants’ anxiousness and reciprocity during the interviews, and the researcher and participants’ fatigue, among others. In short, a reflective diary records the researcher’s and participants’ experiences, thoughts, feelings and opinions throughout the study and also serves as a tool for future reference (Bashan & Holsblat 2017:3). All interviews and

documents were labelled with a coded number, to maintain the anonymity of participants.

3.5.5 Data analysis

The purpose of data analysis is to generate useful and usable information, irrespective of qualitative or quantitative data. Contrary to quantitative data, which usually consists of numbers, words form the basis of qualitative data. Data analysis in qualitative designs is an iterative process whereby obtained data undergo ongoing analysis (Ingham-Broomfield 2015:38). There are different approaches for qualitative analysis, but the central elements embedded in these approaches revolve principally around the familiarisation with the data, the focus on the analysis, coding and categorising the themes, and interpreting the findings (Leavy 2017:150; Mabuzaet al 2014:1). The coding and categorising of collected data in qualitative research contribute to reducing a large amount of data generated following transcription (Alshenqeeti 2014:41). Other important features of qualitative analysis include the transcription of interviews and the personal involvement of the researcher during both the data collection and data analysis process, in which the latter is immersed (Ingham-Broomfield 2015:38).Qualitative data analysis processes are complex and messy owing to the relatively large amount of data generated in the form of text (Denscombe 2014:265).For the purpose of this study, a thematic approach was followed.

3.5.6 Thematic analysis

Thematic analysis is flexible and is the most common and simplest form of analysis in qualitative approaches (Braun & Carke 2006:77; Javadi & Zarea 2016:38; Maguire & Delahunt 2017:2). The thematic analysis approach involves the identification, the reporting and analysis of patterns or themes within the data (Braun & Clarke 2006:83). It is also considered suitable for interpretive qualitative data analysis since it summarises and categorises data rather than analyses it (Maguire & Delahunt 2017:2). There are many approaches to qualitative analysis, but generally the core of the analysis methods

is essentially thematic (Braun & Clarke 2006:83). The authors emphasised that this method of analysis adopts a bottom-up approach in the formulation of themes that are linked to the data. Hence, meanings are drawn inductively, thus interpretations made by the researcher are based on the data, rather than on the theoretical foundation of the study. This process is not linear but recursive, implying that the researcher has to revisit the data set by moving back and forward to understand meanings, experiences and the real world of the participants (Braun & Clarke 2006:94; Javadi & Zarea 2016:36). This suggests that the researcher is deeply involved and active in data collection and analysis, where codes are identified, themes are formulated and named. Thus, the thematic analysis is all about making sense of data.

Braun and Clarke (2006:94-101) identified six steps to thematic analysis. This includes:

1. ***Familiarising with data*** –This consists of reading and revisiting the data, listening to audio-recordings and checking transcriptions to get an understanding for accuracy. This step assists in identifying recurrent statements and patterns of words.
2. ***Generating initials codes*** –This involves the organising of the data and the noting of meaningful ideas by grouping them into a category which will generate codes.
3. ***Searching for themes*** – The codes are examined, sorted and grouped to form potential themes, and the relationships between codes and themes are considered.
4. ***Refinement of themes*** – The identified themes are checked and refined for coherence with each other.
5. ***Defining and naming of themes*** –This requires an analysis of the themes by defining and refining the themes to demonstrate their relevance in terms of clarity, accuracy, and evidence.
6. ***Producing the report*** – This final step focuses on the analysis of the final identified set of themes for write up to enhance their validity.

Although there is a claim that thematic analysis is simple and commonly used in qualitative research, researchers need to avoid certain pitfalls (Javadi & Zarea 2016:40). This may primarily relate to the researcher being too simplistic in his analytic

approach by being pre-judgmental. Consequently, this can potentially impact on the incompatibility of interpretation and analysis of the data with a lack of coherence and inconsistency. In this study, the thematic analysis was aligned with the six steps that were presented, from which the codes, categories, and themes emerged.

The transcripts of the recorded interviews were reviewed and re-checked while listening to the recorder again. Each transcript was read with the participant for confirmation as to whether it reflected their views. A copy of each interview transcript was also forwarded to the promoter for quality checks. The thematic analysis allowed the researcher to determine and compare relationships between concepts during interpretations (Leavy 2017:155). The interviews were co-coded by the promoter as a quality measure.

3.5.7 Measures of trustworthiness

Qualitative research has often been criticised because of the lack of scientific rigour owing to the absence of objectivity and generalisability (Cope 2014:89; Hadi 2016:641).Rigour in quantitative research is assessed through the concept of reliability and validity, while trustworthiness is the term used in qualitative methods to judge its reliability and validity (Cope 2014:89). In this study, there was a triangulation of methods and data sources. During the qualitative phase, data were collected from nurses using an interview guide consisting of semi-structured questions. Data were also obtained from both students and nurses during the quantitative phase through a self-administered questionnaire consisting of pre-determined questions. Leavy (2017:154) argues that the term ‘trustworthiness’ is usually used to evaluate the validity of a qualitative study. The trustworthiness of this study was based on the principles discussed next.

1. Credibility – refers to the truthfulness of the findings with regard to the data analysis and its interpretation. According to Cresswell and Cresswell (2018:266), credibility can be enhanced through:

- ***Prolonged engagement*** – that is, the researcher's involvement in collecting the data to gain an in-depth understanding of the phenomenon. This was achieved through the time spent with participants during and after the interviews, checking the transcripts and data analysis. This process lasted around three and a half months. Also, the researcher's observations and interactions with the participants with whom he was working contributed to his prolonged engagement.
- ***External checks*** – this involves the independent analysis of data by others; in this study, it was undertaken by the graduate colleague who was versed in qualitative analysis. Furthermore, the analysis process was also monitored by the promoter.
- ***Reflexibility*** – this requires the researcher to reflect on his role as an interviewer and to recall whether he has influenced the results. Throughout the conduct of this study, a reflective diary was kept for the researcher to record thoughts, feelings and all events.
- ***Peerreviews*** – a strategy that involves an interpretation other than that of the researcher, which is usually performed by a peer examiner. This was done by senior nurse educators from the CSN.

2. Dependability – is the extent to which the researcher has been consistent in documenting the steps of the data collection and its analysis (Grove et al 2015:392). In other words, how reliable and authentic are the findings. A qualitative study is considered dependable if it has been reviewed by two independent researchers who produce a similar conclusion. In this study, a detailed description of the methods used during all stages of the research was provided, and a reflective diary was also kept. In addition, all available documents and the reflective diary of the researcher can serve the purpose of an audit trail. This allows the reader to follow the various steps undertaken by the researcher to reach the conclusion (Bowling 2014:160; Grove et al 2015:393).

3. Confirmability – requires the researcher to be consistent with the data collection and analysis processes. The researcher must have the ability to demonstrate that those responses are participants' views. This was observed following the completion of data

collection and ongoing data analysis. The researcher set aside his assumptions to avoid subjectivity. This was also reinforced through member checking, by returning to participants to confirm whether the responses were correct and reflected what they narrated. Furthermore, participants' verbatim quotes were also used during data analysis.

4. Transferability – refers to the extent to which the findings relate to other settings or groups. Since purposeful sampling limits generalisation of findings, sufficient depth and details were recorded to get real insights into the phenomenon. Participants from all five regional hospitals were included in the study according to the selection criteria and aim of the study. A thorough description of these processes was provided by the researcher. This is also referred to as 'thick descriptions' (Denscombe 2014:91; Leavy 2017:137) as diverse and rich contextual data were gathered.

3.6 PHASE 2 – QUANTITATIVE PHASE

Quantitative research involves the collection and analysis of data in a structured way using scientific methods (Bowling 2014:214). The obtained data are analysed using statistical procedures which can be either descriptive or inferential (Ingham-Broomfield 2015:35). This requires the researcher to proceed systematically according to a set of established principles to maintain the rigour and objectivity of the study. The philosophical foundation of quantitative research is rooted in positivism, which assumes that phenomena can be measured using a deductive approach (Ingham-Broomfield 2015:33). A deductive approach is based on the premise of general principles or assumptions to explain a phenomenon; that is, the researcher uses logical reasoning drawn from general ideas.

In line with the aim of the study, the quantitative design was used for Phase 2 to gather information from both the students and nurses. The purpose was to investigate the current mentoring practices from two different perspectives, which is also known as data triangulation (Grove et al 2015:513).

3.6.1 Target population

Both nurses and students were considered as participants to form part of Phase 2 of the study. The population of nurses with the same inclusion criteria was used as described earlier in Phase 1. The student population consisted of third-year students completing their DGN. According to the available registers from all regional hospitals at that point in time, the population size for nurses who had completed their top-up Diploma was 996 (N= 996), while the population size for students were 200 (N=200) according to the register of the CSN.

3.6.2 The sample

A sample is generally drawn from the sampling frame, which is a complete listing of every element of the target population (Leavy 2017:268). A probability sample was used for the quantitative phase. This entails the selection of participants through simple random sampling whereby all study elements were given equal chances. Samples selected randomly are not subject to researcher bias, as the selection is left to chance which also enhances the validity of the findings (Grove et al 2015:258). Furthermore, random sampling enhances the representativeness of the study population (Grove et al 2015:526).

The sample size was calculated by the statistician and the margin of error used was 5%. The recommended sample size for nurses was 285 (n=285), and that for students was 130 (n=130). The names of all qualified nurses meeting the inclusion criteria were identified by accessing both male and female registers from regional hospitals as the sampling frame. However, the names of the eight participants who participated in Phase 1 of the study were omitted. The school register was used for student nurses. Students were included in this phase to gain a holistic view of the phenomenon under study. The inclusion and exclusion criteria were as follows:

3.6.2.1 Inclusion criteria

- Male and female third-year students enrolled in the DGN programme.
- Students on practice placements in clinical settings of the regional hospitals.

3.6.2.2 Exclusion criteria

- Third-year students who were posted for their community placements (Psychiatry, Health Promotion and Vaccination unit) were excluded.

3.6.3 The data collection instrument

In a review of mentorship measurement tools, Chen, Watson and Hilton (2016:20) affirmed that instruments used to measure mentoring in nursing drew mainly from business models and mentorship is less mature in the field of nursing. Chan (2002:69-75) developed the CLEI for measuring mentorship in a clinical setting. The tool consisted of 42 items in total. This tool was modified to 32 items and has been tested in a study by Ali et al (2015:4) to measure the effectiveness of the CLE among nursing students in Saudi Arabia. Similarly, building on the work of Chan (2002), Choudhary et al (2014:11-15) also developed another tool known as the CLESE which consisted of 53 items. Both tools were found reliable and valid. These tools were available through open access. Two important points that need to be considered in the design of an instrument include the theoretical framework and the psychometric properties which relate to the accuracy and consistency of measurement (Chen et al 2016:29).In this study, relevant items from these two instruments were identified and incorporated in the data collection instruments for both nurses and students.

Structured questionnaires were used for both students and nurses as data collection instruments. The findings of the qualitative study in Phase 1, the literature review, the objectives and theoretical framework the study, guided the formulation of the questionnaires. Its design was finalised following the recommendations of the

statistician and the promoter. The questionnaires were pre-tested in a pilot study with five nurses and five students, respectively. These nurses and students were excluded from the study and did not form part of the sample. The pilot study aimed to ascertain that participants understood the sentences and identified any flaws in the questionnaires. No ambiguous sentences or other difficulties were noted during this pre-test.

3.6.3.1 Content of the questionnaires

Quantitative research usually makes use of survey questionnaires or psychometric instruments to collect data. In survey questionnaires, the questions are commonly analysed individually while psychometric instruments consist of a series of items to which a score is allotted to represent the concept being measured (Cresswell & Cresswell 2018:203; Durand & Tracey 2014:111). In this study, the data collection tool had both properties of the survey questionnaire and psychometric instrument. The level of measurement was nominal as well as ordinal. The content of both questionnaires for nurses and students were more or less the same, with a slight difference in the number of items. There were 74 items in the students' questionnaires (Annexure F) and 79 items in the nurses' questionnaires (Annexure G).

These were divided into three sections as follows:

Section A. Background information – This section includes the age, gender, qualification, experience, and the units posted.

Section B. Current practice of mentoring – This section relates to how mentoring was being practised and the desired attributes of mentoring.

Section C. Clinical learning environment – This section consists of short responses regarding the ward organisation, communication and relationship, mentoring and barriers to mentoring. It had psychometric properties with responses which were rated on a Likert scale. Part of this section is illustrated inT able3.1

Table 3.1: Likert scale

ITEM No	RESPONSE	SD	D	SLD	SLA	A	SA
38	Mentors give constructive feedback	0	1	2	3	4	5

Strongly Disagree (SD) - 0 Slightly Agree (SLA) - 3

Disagree (D) - 1 Agree (A) - 4

Slightly Disagree (SLD) - 2 Strongly Agree- (SA) - 5

3.6.4 Data collection

Once the lists of names were available, a random selection exercise was conducted by the statistician. This generated the names of the potential participants who were to form part of the study population. Hence, the random exercise provided the names of 285 (n=285) nurses and 130 (n=130) students as respective sample sizes. The participants were then contacted by the researcher. A formal meeting was arranged at the hospital with all nurses who were selected to participate in the study. Similarly, the researcher also met all the students who were in their pre-registration block at the CSN. During these meetings, participants were given an explanation about the purpose of the study and were provided with the information/consent form. Once the consent form was signed, they were given a self-administered questionnaire consisting of structured questions.

Questionnaires usually consist of closed-ended questions which are pre-determined and set in a standardised way to elicit quantitative data (Grove et al 2015:510). Instructions were also given that they should read each question attentively before completing all sections of the questionnaire. Both nurses and students were allowed four days to complete their questionnaires. The completed questionnaires for nurses were then collected from each hospital and that of the students from CSN. However, out of the 285 questionnaires distributed to nurses, only 255 were retained for data analysis. Twenty questionnaires were found uncompleted, and ten participants did not return their questionnaires. Similarly, ten questionnaires for students were not properly

completed, and five participants did not return their questionnaires, leaving the total student participants at 115. Hence, the final sample size for nurses was 255(n=255) and for students 115 (n=115). The response rate for nurses was therefore 89% and 88% for students. As such, there is not a standard range for response rate, but a response rate below 60% is considered sub-optimal, while 75% and above is good (Bowling 2014:280).

3.6.5 Advantages and disadvantages of questionnaires

Data collection instruments have their weaknesses and strengths. Its design from the start of the study requires rigour from the part of the researcher so that it fits the purpose; the information gathered should be accurate and reliable. There are many advantages and disadvantages associated with the use of questionnaires (Bowling 2014:277; Durand & Tracey 2014:111, Zohrabi 2014:254). The advantages include, among others, its cost-effectiveness and data can be collected consistently from a large sample. It is more convenient and flexible for participants to complete a questionnaire than to participate in an interview which is also time-saving. Furthermore, it facilitates data analysis since it is usually designed in collaboration with a statistician. Thus, results can be easily presented in tables, and the absence of interaction of the researcher with participants tends to reduce bias. One inherent strength is that it can be posted to participants in a large geographical area.

Questionnaires have their limitations as well. At times, pre-coded answers may be ambiguous and may not have the same meaning to all participants; and it is not possible to add any other responses. Moreover, the researcher does not have any control over responses and participants do not complete the questionnaire face-to-face with the researcher. This tends to leave little doubts about whom the questionnaires were completed. Moreover, poorly designed questionnaires with an exhaustive list of questions will likely lead to inaccurate answers and poor response rates. Another major disadvantage is that questionnaires are prone to error when gathering information on social phenomena, attitude, and behaviour.

3.6.6 Validity and reliability

By convention, the credibility of research findings is linked to the reliability and validity of a research instrument (Leavy 2017:155). This implies how far rigour was observed by the researcher to enhance the quality of the findings. Reliability refers to the extent to which a research instrument will yield the same results on repeated trials, it relates to the homogeneity of the instrument (Grove et al 2015:510), and also the degree to which it is free from random error (Durand & Tracey 2014:105). On the other hand, validity refers to the extent to which an investigation is measuring what itis supposed to measure (Bowling 2014:170; Cresswell & Cresswell 2018:336); that is, whether the concept has been accurately measured in the study (Heale & Twycross 2015:66). Validity in quantitative methods is determined by three types of validity, namely content validity, construct validity and criterion validity (Cresswell & Cresswell 2018:291; Heale & Twycross 2015:66).

3.6.6.1 Content validity

Content validity refers to the degree to which an instrument incorporates all the characteristics or domains of the phenomenon being measured (Grove et al 2015:502). Hence, the comprehensiveness and appropriateness of the instrument are key elements to be considered in the design process (Cresswell & Cresswell 2018:202). Additionally, Heale and Twycross (2015:66) refer to face validity where the views of an independent observer can be sought to judge whether the instrument purports what it is supposed to measure. The content validity of the questionnaire in Phase 2was established through the literature review, discussions, consultation with the promoter, the statistician, and pre-testing the instrument.

3.6.6.2 Construct validity

Construct validity refers to the degree to which an instrument measures the intended construct (Grove et al 2018:502; Heale & Twycross 2015:67). This is achievable when

the researcher makes use of sufficient definitions and measures of variables (Cresswell & Cresswell 2018:248).Therefore, what matters most is whether the instrument is underpinned by relevant theory and is measuring the underlying attributes. Construct validity can be demonstrated by the use of three types of evidence (Heale & Twycross 2015:66). These include:

- ***Homogeneity*** – that is, the tool measures one construct. In this study, the concept of mentoring was the only construct that was measured with a standardised questionnaire.
- ***Convergence*** – occurs if the instrument measures concepts similar to other instruments. Although the items of the instrument in this study were drawn from other instruments, it differs to a great extent in the sense that it was not a copied instrument.
- ***Theory evidence*** – refers to the degree to which participants' responses reflect the construct variables being measured. In addition to the theoretical aspects of the construct, the theoretical framework guiding the study was incorporated into the questionnaire. Furthermore, relevant conceptual definitions were spelled out in the literature review.

3.6.6.3 Criterion validity

Criterion validity refers to the extent to which a research instrument is related to other instruments that measure the same variables (Heale & Twycross 2015:66), while it also seeks to evaluate the usefulness of the study to determine whether it has elicited adequate information (Zohrabi 2013:259). The questionnaire was designed accordingly so that the findings could be implemented in clinical settings, while the outcome of the study was also presented to a panel of stakeholders for validation.

3.6.7 Reliability

Reliability usually deals with the consistency of the instrument (Heale & Twycross 2015:66; Grove et al 2015:510) in how accurately and precisely it measures the variable. Cresswell and Cresswell (2018:333) also explain that the reliability of an instrument implies that items' responses are consistent across the construct and the scores are internally consistent. There are several ways to assess the internal consistency of an instrument and Cronbach's alpha is the most commonly used test (Heale & Twycross 2015:67). This normally ranges from 0 to 1 and there is no agreeable range, but the minimally acceptable level is 0.70 (Bowling 2014:172). Therefore, the higher the score, the more accurate and precise is the measure. Reliability of the instruments was established following their pre-testing during the pilot study. The Cronbach's alpha of both questionnaires were 0.94 for nurses and 0.93 for students, respectively.

Another attribute of reliability is the stability of the instrument which involves the administering of the same instrument to the same participant repeatedly to assess its tests scores (Heale & Twycross 2015:67). To determine stability there should be strong correlations between the test scores. A correlation coefficient of 0.3 to 0.5 is considered moderate, and greater than 0.5 is deemed strong. This was established during the pilot study where the stability test was performed with one of the participants, and the correlation coefficient was 0.8.

3.6.8 Data analysis

In quantitative studies, data analysis is conducted after data collection is completed, while in qualitative research analysis is an ongoing process (Durand & Tracey 2014:79). Both descriptive and inferential statistics were used for data analysis. The data were drawn from both students' and nurses' perspectives (Annexure F & G). The contents were aligned with the objectives of the quantitative phase, focussing on ward organisation, communication and relationships, mentoring and barriers to effective

mentoring. The data analysis was conducted using computer software SPSS 21.0. Descriptive statistics were used to describe the sample and the variables under study, while inferential statistics allowed identifying relationships and differences among variables (Grove et al 2015:319). Bar charts and tables were used to illustrate the findings. Once the analysis was completed, it was also reviewed and checked by the statistician (Annexure H). The conclusion from the analysis was based on logical reasoning and a set of premises, also known as deductive reasoning (Cresswell & Cresswell 2018:57). The analysis, findings and its integration, along with the discussion, are presented in Chapter 5. Figure 3.1summarises the sequential mixed-method design and the data integration process of this study.

3.7 DATA INTEGRATION

The use of both qualitative and quantitative approaches within a single method also implies there are two sets of data. In this study, data were collected and analysed separately for the qualitative and quantitative phases in a sequential way. There were three sets of data; one from the interviews of the qualitative phase, and the other two sets were from the survey. Berman (2017:1104) argues that it is the mixing or linking of the data sets that define the value of a mixed method and refers to this process as data integration. Fetters, Curry and Cresswell (2013:7) emphasise that data integration can happen at various stages of the study, including the design, methods or interpretation level. The authors further point out that integration can occur through connecting, building, merging or embedding. In this study, integration occurred at the design level through building the data collection tool, while merging occurred at the interpretation level during quantitative analysis. Data from the first phase of the study were used to build the data collection tool of the second phase, while both data sets from the quantitative phase were brought together for comparison along with the identified themes of the qualitative phase. The final integration took place where the findings were synthesised using Dickoff et al's (1968) survey list to develop the clinical mentoring framework for nurses. The whole process is illustrated in Figure 3.1.

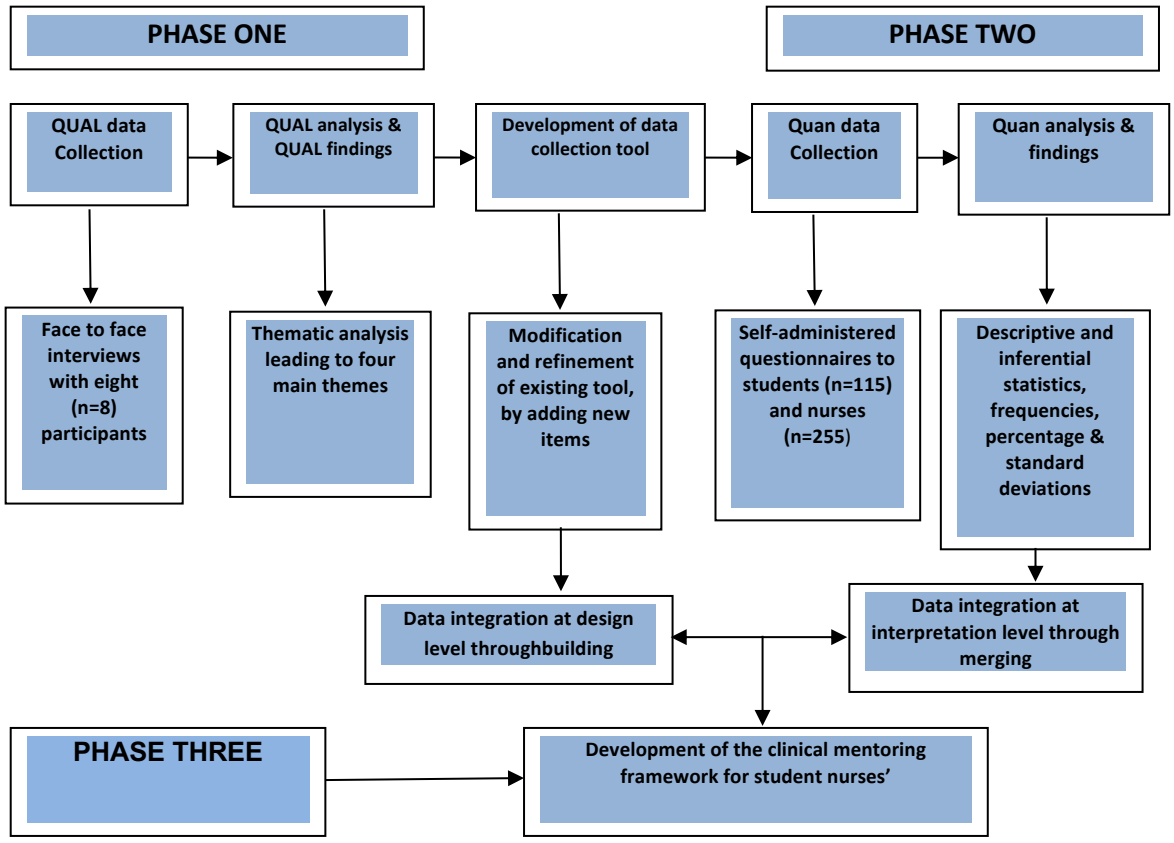

Figure 3.1: Exploratory sequential mixed methods design and data integration

3.8 PHASE 3: DEVELOPMENT OF A CLINICAL MENTORING FRAMEWORK

The third phase of the study consisted of the development of the framework. The survey list of Dickoff et al (1968) served as a roadmap in the formulation of the conceptual framework. The survey list is related to six components of activity, namely the agent, recipient, context, dynamic, procedure, and terminus. These steps are elaborated on and outlined in Chapter 6. The findings of both qualitative and quantitative phases also formed the basis of the framework. Inductive reasoning was mainly used to describe and explain concepts regarding their relationships. The framework was analysed and evaluated according to the pragmatic and epistemic criteria as described by Risjord (2018:9). This evaluation process is further explained in Chapter 7. The framework was

then presented for validation to a panel of key stakeholders comprising of the Director of Nursing, Principal of the CSN, members of the Nursing Council, President of the National Nursing Association and a Senior lecturer in Nursing from a private institution. These stakeholders were considered key role-players since they were in a position to influence policy. The framework was validated following clarifications made by the panellists on a few points on which they laid emphasis.

3.9 ETHICAL CONSIDERATIONS

Ethical issues need to be considered prior to conducting research and throughout the study. Any research involving human participants should rigorously follow ethical principles to protect the integrity of the research and the participants, irrespective of the method used (Grove et al 2015:98). To protect the rights, safety, and wellbeing of participants, it is essential to comply with ethical principles because of the in-depth nature of the study process (Arifin 2018:30).It is also vital what values the researcher holds to the conduct of a study (Akaranga & Makau 2016:3). Hence, if the ethical principles and values are not upheld during the conduct of a study, it puts into question its credibility. The main ethical principles which commonly guide researchers in their study include autonomy, beneficence, non-maleficence, and justice (Akaranga & Makau 2016:5-7; Australian Council for International Development (ACTFID) 2017:8). These principles were observed during both phases of the study.

Autonomy –the principle of autonomy refers to the right to self-determination. In this study, the participants were autonomous; they were free to make a decision and express their decision. Participants were invited to participate in the study after they were briefed by the researcher and provided with relevant information. Their participation was voluntary and at no point in time were they coerced to join the study. They were also told that they could decline or withdraw from the study at any time without any penalty. They received no reimbursement. Sharing completeness of all aspects of the study through informed consent to the participants is considered a key element in any research (Bowrey & Thompson 2014:23). The nature of the study and

emphasis was laid on the importance of their participation. In this study, they were given an information/consent form to sign which provided background information of the research, its aim, and the telephone number of the researcher. A copy was handed to them once it was signed. Thus, both verbal and written information was given to all participants. Likewise, they were also informed that the researcher could be contacted by telephone regarding any queries, doubts, or in terms of the outcome of the study.

Participants were assured that the data would be managed and kept under the custody of the researcher to maintain confidentiality and anonymity since their names would not appear on the questionnaires. This would be subsequently destroyed following publication and dissemination of the report. The voluntary and informed consent allowed the participants the right to freedom of expression as to whether to participate or not to participate in the study, whereby the legal liability of the researcher is reduced (Arifin 2018:30). However, for a participant to give informed consent it is imperative to disclose all information in all honesty and truthfulness, including the benefits and any risks associated with the investigation (Akaranga & Makau 2016:7). Benefits within the conduct of a study imply ‘doing good’ which draws from the ethical principle of beneficence.

- ***Beneficence*** – In principle, the outcome of any research should serve and promote the welfare of the people to avoid bias or deception; that is, it should benefit the target and general population under study. The benefits of this study included effective clinical mentoring for student nurses and competent pre-registration nurses to deliver quality care. Researchers must avoid, prevent and minimise the risk of harm or discomfort to study participants. In other words, they should ‘do no harm’ to participants, which is also referred to as the ethical concept of non-maleficence (Akaranga & Makau 2016:7).
- ***Non-maleficence*** – The principle of non-maleficence includes both psychological and emotional harm. In this study, the researcher ensured that participants were not subjected to stress or anxiety through long interviews or uneasy questions. There was debriefing with the participants after each interview during the qualitative phase.

The questions in both the questionnaires and the interview schedules were phrased in a meaningful way not to embarrass the participants. They were informed that the purpose of their participation in the study was to provide better insight regarding mentoring in the local context. Their participation would contribute to improving the mentoring system in the clinical settings while enhancing the practice training of students and improving quality care of patients.

- ***Justice*** – Refers to the right to fair treatment. In this study, all participants were given the same consideration without any discrimination. They were invited to participate in the study according to the selection criteria. All participants in the qualitative phase were allowed to give their responses thoughtfully, and adequate time was allotted for this. Similarly, all participants in the quantitative phase were requested to submit their self-administered questionnaires within four days. Due respect and the needs of the participants were attended during the data collection process, and the researcher maintained consistency in the processes throughout the phases of the research.

These principles were given due attention by the researcher, and every step was taken to ensure compliance with regards to the research process.

3.10 SUMMARY

This chapter provided an overview of the mixed-method approach adopted by the researcher. The research process of both qualitative and quantitative phases was described with emphasis on the key components with regards to the research design and methodology. The choice of the design and the various approaches were elaborated on. This included the population, the sample, and the data collection process and data analysis methods. The design of the data collection instrument for the qualitative phase and its trustworthiness were also explained. Similarly, the validity and reliability of the quantitative tool were also discussed. Finally, ethical aspects and permission to conduct the study were considered, and the development of the framework was explained.

The next chapter will present the analysis and discussion of the data collected from the qualitative phase.

CHAPTER 4
QUALITATIVE ANALYSIS, FINDINGS, AND DISCUSSION OF PHASE 1

4.1 INTRODUCTION

This chapter provides an analysis and discussion of the findings from Phase 1 of the study. It also addresses the research objective in response to the qualitative phase of the mixed-method design, which focused on the experiences of qualified nurses. In line with the qualitative approach, data were collected using an interview guide through face-to-face interviews. The content of the interview guide was aligned with the aim and objective of the study. It attempted to elicit how mentoring was practised as experienced by the qualified nurses, the attributes of a mentor, and the constraints in the CLE.A purposive sample was used and the sample size consisted of eight nurses. A thematic analysis was used for data analysis. The findings are presented accordingly with the main themes, categories, and codes along with verbatim quotes in *italics*. The findings are discussed with relevant supportive literature in the sections that follow.

4.2 PROFILE OF PARTICIPANTS

The profile of the participants is shown in Table 4.1. The sample for this qualitative phase consisted of eight participants following data saturation.

Table 4.1: Profile of participants

PARTICIPANT	SEX	POSTING	QUALIFICATION	EXPERIENCE
PA-001	Male	ICU	Top-up Diploma	33 years
PB-002	Male	Theatre	Top-up Diploma	26 years
PC-003	Female	orthopaedic	Top-up Diploma	20 years
PD-004	Female	ICU	Top-up Diploma	22 years
PE-005	Female	Gynae	Top-up Diploma	28 years
PF-006	Male	Medical	BSc (Hons) Nursing	30 years

PARTICIPANT	SEX	POSTING	QUALIFICATION	EXPERIENCE
PG-007	Male	Surgical	BSc (Hons) Nursing	32 years
PH-008	Male	Orthopaedic	BSc (Hons) Nursing	33 years

There were five male and three female nurses who participated in the study. Of the eight participants, all were graduates, with five of them holding the Top-up DGN while three were degree holders in nursing. Most of the participants had been in the service for more than 25 years. The majority of the participants were posted in general wards such as medical, surgical, gynaecology and orthopaedic, while three were working in speciality units like intensive care units and operation theatres. The majority of the participants were male nurses. A greater number of the wards and other units in the regional hospitals are male wards. However, the staffing ratio regarding male nurses to female nurses is almost 1:1 (MOH & QL 2016).

4.3 THEMES, CATEGORIES, AND CODES

Table 4.2 provides an overview of the main themes and how they emerged from the meanings of the codes and categories. The findings are then presented and discussed.

Table 4.2: Overview of main themes, categories and codes

THEME	CATEGORY	CODES
1.Mentoring as per definition is not practised but rather a form of clinical accompaniment resulting in the practice being less effective for (its) purpose	1.1 Lack of policy directives and standards	
	1.2 Current activities are informal	1.2.1 Lack of continuity
	1.3 Absence of recognition as mentor leads to feeling undervalued in the task	
	1.4 Absence of commitment and motivation	

THEME	CATEGORY	CODES
	1.5 Nurses that are clinically task-orientated	
	1.6 Role conflict	1.6.1 Duality of roles: practitioner and guide
		1.6.2 Underprepared for the role
	1.7 Lack of resources; human and others	1.7.1 Monitoring
	1.8 Mentoring as a routine task	
	1.9 Self-reliant for their role and training	1.9.1 Lack of incentives
	1.10 Student issues	1.10.1 Large student numbers
		1.10.2 Students are left to their own devices
2. A variety of activities/roles are described in everyday clinical practice	2.1 Facilitator and advisor	
	2.2 Coach as a trainer	
	2.3 Supervision and guidance	
3.Aspects of mentoring	3.1 Relational and communication component- mostly related to clinical nursing issues	3.1.1 Trust, respect and confidence
		3.1.2 Role model
	3.2 Promotion of learning	3.1.3 Providing feedback
	3.3 Documentation	

THEME	CATEGORY	CODES
4. Pre-requisites needed for the mentoring process	4.1 The need for policy and directives for all stakeholders	4.1.1 Collaboration between stakeholders
		4.1.2 Negotiating the way forward
		4.1.3 Proper prior planning
		4.1.4 Regular meetings between stakeholders
	4.2 Training of mentors: a short course	4.2.1 Clinical component: teaching and educational skills
		4.2.2 Relational skills
		4.2.3 Management skills
		4.2.4 Leadership skills
		4.2.5 Mentoring skills
	4.3 Clinical setting requirements	4.3.1 Adequate resources
		4.3.2 Students ratios
	4.4 The role of the mentor	4.4.1 Designated position
		4.4.2 Demonstrating leadership
		4.4.3 Motivator
	4.5 The responsibilities of the student	4.5.1 Empowerment
		4.5.2 Showing interest and willingness

4.3.1 Theme 1: **Mentoring as per definition is not practised but rather a form of clinical accompaniment resulting in the practice being less effective for (its) purpose**

In principle, mentoring within nursing is a strategy used to support students learning during their clinical placement (Oluchina & Amayi 2016:179). This support is provided by qualified nurses who act as mentors. The practice of mentoring differs according to context, but 'how', 'when', 'what' and by 'whom' it is practised is vital to the preparation of students for their fitness to practice. In this study, participants were asked to share their experiences as a mentor. The views of the participants indicated that the current support system for students in the clinical settings does not reflect what mentoring is all about. Some of the participants were straightforward in their answers as expressed through the following quote:

> *"I do not think mentoring of students is done in this way if someone looks at the definition of a mentor, according to me qualified nurses in the local context cannot be considered as mentors" (PD-004)*

This also denotes there is awareness among participants about what mentoring is about, although they do not give a clear definition of mentoring. Moreover, participants also questioned their practice regarding their roles as mentors in the wards. Three participants stated that

> *"Once again the role of the mentor in the local context is not clear as it is not a post in the local context" (PC-003)*

> *"Firstly I will like to say that to the best of my knowledge the term mentor is not used in the local context" (PE-005)*

> *"It will be difficult to practice mentoring as in the UK because Mauritian nurses are not trained to be mentors" (PG-007)*

The definition of mentoring varies, and despite there being an established standard, there is no universal description of what mentoring is about (Matin 2017:1). Additionally, within the nursing literature, mentoring is practised differently across settings (Brand 2016:2) since there is a lack of agreement on the poorly defined roles of mentors (RCN 2015). One participant, for example, stated that:

> *"Mentors should not just only supervise, but they should also teach and assess the students" (PB-002)*

The role of the assessor in mentoring practices is not common and is often contested. The lack of competence for assessment among mentors in their role as the assessor is a major weakness as they need to be supported by educators (Douglas et al 2016:37). This might, however, become a contextual need. It is therefore important to make the distinction between other similar terms associated with mentoring to avoid confusion.

The participants provide support and guidance to the students who are on placement. This also implies there is always the presence of qualified nurses when students are performing clinical procedures or providing nursing care to patients. Thus, students are not left alone but are being accompanied in their clinical practice by qualified registered nurses where there is coaching in one way or another. This support takes the form of clinical accompaniment since the nurses guide and give direction to the students.

> *"but as a qualified nurse, I have to support students when they are posted in the wards…The support which I give to students is something which has been routinely practiced by other nurses… nothing has changed" (PF 006).*

> *"Usually I just show them how to care for patients and how to perform a nursing procedure...most of the time nurses spend little time and are brief when they coach students"(PG007)*

"my role in supporting students consists mainly of supervising and guiding students when they are doing nursing care and other nursing procedures" (PE005)

Clinical accompaniment refers to the directed support and assistance provided to students by registered nurses or midwives (South African Nursing Council SANC 1992:2). While it is considered an important means to train and educate competent nurses (Motsilanyane 2015:1), it has also been reported that clinical accompaniment tends to disregard students' status, leading to poor supervision with lack of interest in teaching from nurses (Letswalo & Peu 2015:351). The experiences and observations shared by the participants demonstrate that the actual local mentoring system is similar to clinical accompaniment. This situation is probably linked to the fact that the mentoring system has established itself as a routine task. It has also not undergone any changes owing to a lack of policy directive to improve the system. However, by definition, the accompaniment cannot be equated to mentoring as this approach predominantly focuses on psychomotor skills, rather than on cognitive skills which facilitate learning through the integration of theory into practice.

4.3.1.1 Lack of policy directives and standards

In simple terms, policies are meant to guide our actions. According to the Center for Disease Control and Prevention (2016), a policy can be rules, regulations, guidelines or directions. Within the context of nursing in healthcare, this likely refers to principles or steps that have to be followed regarding a specific treatment, procedure or intervention. Policy directives are binding and place responsibility and accountability on staff. This ensures consistency and maintains uniformity to standards. Participants in this study confirmed that there was no uniformity in the way students were being mentored. The following quotes indicate the absence of clear direction regarding the mentoring system.

"The main problem I think there is not a protocol regarding mentoring of students at hospital level" (PA-001)

“Maybe it is because the way students are mentored is done not according to a written protocol” (PB-002)

“But I must say there has never been a clear policy in the wards how to support students who are on placements” (PD-004)

“I must say there is no uniformity the way the students are being supported in the ward” (PH-008)

The collaboration of all concerned stakeholders is an essential element for policy directives to be effective. Mentoring does not take place in isolation (Sambunjak 2015:49), but involves the support of top management, the training institution, the regulatory body and professional associations which are directly linked to nursing. According to the participants, the lack of policy directive regarding mentoring in the local context is likely due to uncoordinated efforts and support from every stakeholder. Effective mentoring is dependent on the mentor-student relationship and other factors which influence its good practice (Houghton 2016:47), while standards within the CLE are either partially met or not met; this ultimately compromises the learning needs of students (Zakaria & Rahman-Gheith 2015:35). Standards regarding the practice of mentoring can only be maintained if it is regulated, but factors such as the lack of organisational support and resources, along with poor teaching, have been identified as barriers to the proper upholding of standards by both students and mentors (Rajeswaran 2016:1). Standards ensure not only safe practice but also gives formal recognition and enhances professionalism.

4.3.1.2 Current activities are informal

Participants in this study were unanimous in recognising that mentoring was being practised informally. No formal records were kept, and they lacked training as educators and mentors.

"I think this can not be compared to what is taught at school...as it is very informal. I must also say that as a qualified nurse I am not trained in teaching" (PH-008)

"...and the way it is done appears to be informal" (PF006).

"This exercise allows me to assess what they have learned. I do it in an informal way" (PA-001).

Participants felt that nurses were unprepared to assume the role of a mentor:

"But the reality is that we have not been trained for that (to mentor students)" (PB -002)

"In fact I believe that qualified nurses supporting students in the ward are not prepared to carry such a task...it is more technical and related to education that educators are the right people to assess the theory-practice gap" (PE-005)

"At time some nurses also feel that they are not prepared to assume the role" (PF-006)

As the mentoring activities were performed in an informal way, it could be perceived as being unofficial. This also implies that less consideration or less recognition is given to mentoring. Consequently, such a situation can eventually lead to frustration and poor motivation among qualified nurses who support students, thereby affecting the practice of mentoring. In addition, it is also obvious that untrained nurses will feel underprepared to take the role of mentor. This could be a result of poor attention given to mentoring by policymakers. Indirectly, this could also contribute to informal mentoring which, in turn, can affect the professional development of the students. It, therefore, follows that informal mentoring by untrained mentors could be viewed as poor practice standards as

opposed to formal mentoring generally based on the premise of good practice with trained mentors.

In general, when something is formal, it is also considered as official. Hence, formal mentoring is recognised as being official and established within the system. In their study, Oluchina and Amayi (2016:179) found that the majority of mentees preferred formal mentoring to informal mentoring, as it motivated students to learn and promoted confidence, contrary to informal mentoring. However, the authors also pointed out that informal mentoring has its merits when the students show eagerness to learn and progress. These findings support how the practice of mentoring in the local context is inconsistent with formal mentoring.

Grossman (2013:2) maintained that mentoring should be formal, particularly when the relationship is between an experienced professional and non-experienced professional. Also, trained mentors are pivotal to any mentoring system, as Douglas et al (2016:37) put it. The authors reported that mentors require support in term of training and partnership with the training institution to better meet the needs of the students.

4.3.1.3 Absence of recognition as mentor leads to feeling undervalued in the task

The role played by any staff within the health system has its significance which also indicates the position held by the employee. The participants pointed out that they felt undervalued in discharging their duty. The following statements described how they were being considered:

> *"as a nurse, I wish I could bring my contribution about what a mentor does, but unfortunately, I will never be recognised as a mentor" (PA-001)*

> *"In my view, the mentoring role which nurses fulfil is not recognised and valued by the management" (PF-006)*

"but it is sad to say that I did not get the full support of management and my colleagues..." (PG-007)

As discussed earlier, mentoring in the local context is informal and is practised by untrained qualified experienced nurses. It is most likely for this reason they are not recognised as mentors, and their contribution is not valued. However, not all nurses are involved in mentoring students. The debate as to whether all nurses should become mentors has led to the publication of a policy paper following a study conducted in the UK by King's College (2013). It was found that the quality of mentoring would suffer if it is practised by nurses who do not have an interest in nursing education. Although this was an important highlight of the policy paper, it also reflects, to a great extent, the current local situation as portrayed by the participants. Nonetheless, there is a consensus among policymakers that the role of the mentor should be reviewed for its recognition and valuable input within the scope of nurse training and education (RCN 2017).

4.3.1.4 Absence of commitment and motivation

Since mentoring in the local context is not formally practised or practised according to any protocol or guidelines, it is difficult to ascertain how motivated and committed the qualified nurses are to mentoring. It would seem that some mentors hardly engage themselves in mentoring students if they feel they are not being given due consideration and support.

"I have noted that with time many qualified nurses are reluctant to supervise students during their placement." (PB-002)

"but other problem that I have observed is that although some staff support students, it is done without any commitment, that is it is done rarely" (PD-004)

"I think they lack motivation and due consideration is not given to them." (PF-006)

"that not all staff is supportive to students and at time some nurses adopt negative attitudes" (PC-003)

"I have noted that mentoring is given less importance because it appears that management does not care about how students' placement is going" (PE-005)

"...I think the management also does not give due attention to mentoring in the ward" (PG -007)

"At the time I also feel that student clinical placement is not a concern for the ward manager" (PA-001)

Participants were concerned by the lack of interest and attention shown by their colleagues and management with regards to mentoring. The reasons for this might vary. For example, the lack of interest among nurses to engage in mentoring could likely be attributed to the fact that student mentoring does not form part of their duties. It could also be assumed that nurses prefer caring for patients to dedicating time to students' learning. Promotion and remuneration could be another reason for their unwillingness to give full support to students. A mentoring system needs the collaboration of all concerned stakeholders, particularly the management, to respond effectively to the needs of the students. Thus, without the firm input from the stakeholders, a mentoring system would be unsustainable and potentially lead to nurses' demotivation and poor involvement in mentoring. These findings also corroborate other studies.

Peak and Kelly (2016:16) discovered that the lack of commitment from management would deprive mentors of the necessary tools, training, and skills to practice mentoring effectively. However, the absence of commitment and motivation on the part of the mentors is also exacerbated by other factors associated with the CLE, as highlighted in a study by Bvumbwe, Malema and Chipeta (2015:933). It was reported that poor learning environments, lack of skills among mentors, and poor faculty support tend to

lead to frustration and demotivation. In contrast, both students and mentors have a relational obligation towards each other to keep the mentoring process ongoing through passion and engagement (Eller et al 2014:820).

4.3.1.5 Nurses are clinically task-orientated

Participants felt that the routine nursing practices took precedence over the mentoring and support of students, or were left to a specific group of registered nurses. This indicates that nurses were devoting more time to the care of patients. This practice is not new in CLE, and in most cases, it is likely associated with staff shortage. In principle, staff shortage is a common problem experienced daily across all clinical settings. Since the clinical settings are service-led, it is obvious that the provision of care to patients will have priority, rather than supporting students. Yet one participant maintained that qualified nurses are also supposed to coach students:

> *"thus the practice training is left on the qualified nurses who are supposed to coach the students" (PH-007)*

Another participant observed that nurses who were doing bank sessions were more engrossed in their clinical tasks. These nurses form part of a pool of nurses who are often available to cover staff shortages and absences when required. Their presence was to ensure adequate staffing to care for patients.

> *"nurses who do bank sessions and extra duty are more concerned with their tasks" (PF-006)*

The findings, therefore, suggest that mentoring students in clinical settings receive less attention from nurses. Oluchina and Gitonga (2016:23) also reported that inadequate resources, workload and clinical responsibilities leave mentors with little time to engage in mentoring. Peak and Kelly (2016:42) recognised that nurses should be well conversant with their clinical practice, but they should also spare a little time to the

coaching of students. It is thus obvious that nurses in their dual role as a nurse and a mentor tend to devote most of their time to patients' caring, which hinders their effective role as a mentor.

4.3.1.6 Role conflict

The nurse, as a carer and mentor, can likely face dilemmas when the latter has to prioritise his tasks; that is, whether to firstly focus on caring or mentoring. Some participants said:

> *"The question that I usually ask where I should give more time; patients' care or students' training. I honestly think it is patients' care because in the ward they have priority over other issues… and as such, I find myself in a conflictual role" (PF-006)*

> *"I must say that it is difficult for me to give the maximum of myself to support student learning...because I have two roles to fulfil...firstly to provide care as a nurse to patients and secondly to guide and coach students" (PE-005)*

> *"all qualified nurses should support and help in the training of student nurses. So as you can see qualified nurses have that double role despite we are not trained for that" (PG-007)*

These experiences reflect a major challenge faced by participants in their daily work. Caring for patients and supporting students in an educational role can be demanding and stressful (Bvumbwe et al 2015:934), particularly if the mentor lacks confidence (Benette & McGowan 2015:454). Indirectly this can likely affect students' professional growth and performances if the mentor overlooks these aspects. Although patients' care should have priority, mentors must also support students' learning. The conflict of interest exists between the professional roles of nurses and that of facilitating the professional growth of students (Setati & Nkosi 2017:131). However, role conflict is a

normal, inevitable phenomenon that one experiences when it comes to education (Pishgooie, Rahimi & Khaghahzinadeh 2014:69). The authors argue that it is important to understand the nature of role conflict in order to mitigate its negative impact on the students.

4.3.1.7 Lack of resources; human and others

Lack of resources can affect the overall performance of an organisation, but human resources remain the key driver for the effective running of an organisation (Burma 2015:89). Staff shortage in clinical settings will have an impact on mentoring. In this study, the majority of the participants reported that staff shortage was a major barrier to mentoring and other concerns were related to workload, lack of equipment, the time factor, overcrowded wards, students' shifting and lack of collaboration. Some participants asserted that:

> *"In fact shortage of nursing staff is a common problem in all the wards where I have been working" (PH-008)*

> *"many constraints like frequent staff shortage, lack of equipment… overcrowded wards and poor collaboration among staff" (PB-002)*

> *"I think that time factor and staff shortage are two common constraints that do not allow me and other colleagues to give time to the students" (PE-005)*

> *"staff shortage and lack of equipment are two common constraints that also affect mentoring" (PE-007)*

> *"You have workload, staff shortage and the daily shifting of students to other units from their placement" (PH-008)*

Similar findings have also been reported in recent studies (Dlama et al 2015:57; Mwale & Kalawa 2016:1). Lack of resources in the wards may be contextual, but managers should ensure that basic resources are always available to meet the standards of care. A clinical setting equipped with all resources will promote mentoring; otherwise under-resourced settings represent a real threat to effective mentoring, especially when students form part of the workforce (Mwale & Kalawa 2016:1).

The problems encountered by mentors in clinical settings may be common, but there are also other factors, such as a lack of feedback, incompetency of instructors, an unsupportive environment, poor supervision and lack of evaluation (Baraz et al 2015:57). Monitoring students by CSN was also viewed as a major shortcoming as highlighted by two participants:

> *"what the students do during their placement is not monitored by the school of nursing" (PB-002)*

> *"and neither there is monitoring from school regarding the theory-practice gap" (PH-008)*

The training of students is not solely dependent on the mentors in clinical settings, but more importantly, supervision and coordination from the training institution are important for an effective training system. Students tend to assume that their practice training is monitored by the training institution through frequent visits from educators. For instance, there should always be resource persons from the training institution to monitor and supervise the quality of the students' clinical placement (Muthathi, Thurling & Armstrong 2017:1; NMC 2010). A well-structured clinical placement for students tends to benefit both the mentors and the students and should not be considered as a routine aspect of training.

4.3.1.8 Mentoring as a routine task

Participants in this study felt that the practice of mentoring was part of the routine nursing task. There also seems little critical thought going into the practice as the nurses present their own experiences of being mentored/supported as students.

> *"The support which I give to students is something which has been routinely practiced by other nurses…nothing has changed" (PF-006)*

> *"This is the problem when something becomes routine and the non-involvement of the training institution regarding students' placement" (PG-007)*

> *"The mentoring system in place is an established one which requires all qualified nurses to support students training in the wards" (PG-004)*

> *"During my career as a registered nurse, I have always learned from my seniors who have been my mentors and am applying the same principles" (PA-001)*

Historically, within nursing, many procedures and tasks are organised routinely and tend to become ritualistic with time (Hutchinson & Jackson 2015:2). There are many possible reasons for this, but the unwillingness to change practice and failure to keep pace with updated knowledge largely contributes to maintaining routine practice (Rajeswaran 2016:476). Rituals in nursing might be helpful in achieving health outcomes but should not persist as it can be harmful and compromise the outcomes as well (Greenway 2014:3584). The significance of this argument cannot be underestimated when it comes to mentoring. As a practice-based discipline, the nursing profession is increasingly orientating itself towards evidence-based care. Thus, if a ritual practice is dominant, those involved in the mentoring of students are likely to adopt the same culture. Perhaps this is why the mentoring system in the local context has remained static. Over the years, the practice of mentoring has been continuously evolving, and its role needs to be re-examined with regards to the needs of students and staff who are expected to

act as mentors (Tengah 2016:38). Hence, the practice of mentoring as a routine task is not conducive for the professional growth of the students.

4.3.1.9 Self-reliant for their role and training

Although participants acknowledged they were not qualified mentors, they were fulfilling their role according to what has been practised over time. One participant commented that:

> *"During my studentship, my seniors have been guiding and assisting me and now as an experienced nurse I am sharing my knowledge with the students just as they did" (PH-008)*

Another participant expressed his concern regarding the follow-up of students during his absence:

> *"I will also like to say that the fact we work on a shift system, does not ensure proper follow up of students by the same mentor" (PE-005)*

Thus, the participants were dependent on themselves in supporting students. It would seem that this approach is likely to be perpetuated if due consideration is not given regarding its impact on the quality of training and education of students, particularly in the context of the new DGN. One participant rightly pointed out that:

> *"I will not criticise the system, but I must say that this system is outdated and need to be reviewed" (PG-007).*

This might be why nurses showed little interest in supporting students; the mentoring system has remained static and they felt unsupported in what they were doing. For instance, there was no professional development or other incentives. Many nurses may have the willingness to support students' learning, but too often they may also not feel

inclined to do so, as they do not perceive this role to be rewarding (Douglas et al 2016:34). Nonetheless, it is important to consider those factors that lead to frustration among mentors which can negatively impact on the quality of mentoring (Rylance et al 2017:408). This commonly includes lack of resources, work pressure, and poor collaboration. Moreover, career progression, structural changes of workload and the training needs of mentors are just as important in sustaining a successful mentoring system (Peiser, Ambrose, Burke & Devenport 2018:2). Thus, mentoring will likely thrive in a supportive environment, but student issues should also be taken into consideration.

4.3.1.10 Students issues

Since mentors deal with students, there are issues pertinent to student numbers and placement which results in a lack of support. Some participants raised concerns regarding issues related to students:

> *"At times there are also too many students in a ward, students are requested by the management to help and eventually they are left on their own without any coaching" (PD-004)*

> *"and thus the students are left on their own and just remain like a passive observer...I believe this does not benefit the students." (PH-008).*

> *"but unfortunately I must say that very often the students had to struggle on their own without any support..." (PG-007)*

The shortage of staff not only leads to the redeployment of nurses but also students as they form part of the workforce. As a result, students spend less time in their placement and are often unattended and unsupervised at ward level. Students tend to rely on themselves in such a situation, but the outcome of this type of support is not productive to the students. On the contrary, the most preferred activities which students value include teaching and explaining, support, supervision, and encouragement (Foster et al

2015:18). Overcrowded wards have also been identified as a barrier to mentoring as it is not easy for the mentor to coordinate a large group of students (Dlama et al 2016:57).

4.3.2 Theme 2: A variety of activities/roles are described in everyday clinical practice

Participants in this study stated that they were performing various tasks and activities in their role as mentors. They were guiding, supervising, coaching or facilitating students' placement.

> *"I always ensure that all procedures are performed under guidance in the presence of nurse…helping and facilitating students during their placement." (PA-001)*

> *"I see myself in the role of a coach who facilitates the training of students in the clinical settings" (PD-004)*

> *"and all through their placement they are guided, supervised and coached by experienced nurses." (PH-008)*

As noted, participants felt that they were fulfilling their role as a mentor through the various tasks they were performing. In fact, the terms 'coaching', 'supervising', 'guiding' and 'facilitating' are related to mentoring, but they have different meanings. These terms can be used interchangeably with a mentor since these elements are present in mentoring relationships (Green & Jackson 2014:80; Peak & Kelly 2016:19). The authors contend that the role of the clinical nurse mentor in the UK is to supervise, teach, assess and facilitate students' learning in the clinical setting as outlined by the NMC (2008) in its standards with regard to supervising, learning and assessing in practice. Drawing from this standard, it therefore appears that the mentoring system in the local

context does not encompass teaching and assessing. This further attests the fact that students' support is in the form of accompaniment.

4.3.2.1 Facilitator and advisor

In general, qualified nurses have broad responsibilities in their mentoring role. Whatever kind of support they provide is perceived as that of a facilitator; that is, the mentor tends to assist the students and attend to their needs. This is reflected in the following quotes as stated by participants:

> *"we facilitate their practice so that they can also apply what they have learned at school" (PE-005)*

> *"advice that I usually give to students is…" (PD-004)*

Ryan and McAllister (2019:281) point out that many nurses tend to facilitate students' clinical practice by preparing and informally helping them. They argue that these nurses act like clinical facilitators. Additionally, mentors support students in their clinical placement through a variety of roles, such as a facilitator, advisor, counsellor, supervisor, leader, role model, teacher, and assessor (Vinales 2015:532). These characteristics are demonstrated depending on context and circumstances. Despite the experiential learning which the nurses have acquired, it is to be acknowledged that they are not conversant with the pedagogical aspects of mentoring.

4.3.2.2 Coach as a trainer

With regard to mentoring student nurses, coaching is beneficial to students as it allows them to take responsibility in identifying their learning needs and practice under supervision (Huggins 2016:28). The following quotes illustrate how coaching is practised:

“most of the time nurses spent little time and are briefed when they coach students” (PG-007)

“I must say that it is difficult for me to give the maximum of myself to support student learning…firstly to provide care as a nurse to patients and secondly to guide and coach students” (PD-004)

Within nursing, coaching simply refers to the empowerment of students or nurses through training so that they can adapt to changes in their professional life (Walker-Reed 2016:43). Coaching has been found to reduce the workload of mentors by allowing students to be more responsible and accountable in identifying their own learning needs (Huggin 2016:30), while it also motivates staff, enhances their skills and contributes to their professional development (Stewart-Lord, Baillie & Woods 2017:85). Arguably, the mentor can use coaching as a skill, but one does not need to be a mentor to become a coach, or vice versa.

4.3.2.3 Supervision and guidance

Supervision is an important aspect of management that seeks to monitor whether organisational performance is in line with its objectives. Of the various roles performed by the mentor, supervision and guidance form part of mentoring. This was highlighted by one participant

“that my role as a mentor is to guide and supervise them...that is to ensure that they can do things in the right way and be able to do it on their own” (PF-006)

Within nursing, the term ‘clinical supervision’ is commonly used and has both an educative and supportive function (Habimana, Tuyizere & Uwajeneza 2016:42). Supervision promotes safe practice to protect patients and empowers the supervisee to become an independent professional to fulfil the role of the supervisor (Moxham & Gagan 2015:37). However, the link between mentoring and supervision is not clear cut

as professional growth takes place under the guidance of a supervisor or mentor, while it also provides opportunities for nurses to support each other in ensuring better patient outcomes (Bah 2016:314). Supervision can, therefore, be considered as one function of mentoring as it also guides safe practice in a professional environment.

4.3.3 Theme 3: Aspects of mentoring

Although the mentoring system in the local context was informal, some activities and tasks undertaken by the participants were – to some extent – similar to what mentors commonly do. This consisted principally of relational and communication aspects, feedback and learning.

4.3.3.1 Relational and communication aspects

In principle, mentoring requires close collaboration between the mentors and students. This collaboration is based on the premise of a trusting relationship which is at the heart of mentoring (Joubert & De Villier 2015:1). Arguably, it is also a professional relationship where skills, knowledge, and experiences are shared by both the mentor and the mentee. Participants in this study stressed the importance of a good relationship. The main aim of the mentor is to prepare the student for his fitness to practice. One of the eight competencies which the mentor must demonstrate is "to establish effective working relationship" (NMC 2008). A participant explained that such a relationship requires trust and respect as illustrated in the following quotes. This view is typical of other participants as well.

> *"He should command respect from all staff and build a good relationship with the students. he must be knowledgeable and trustful as well" (PE-005)*

> *"he must be friendly and always listen and give feedback to students...that is he must value students and keeps a good relationship with them" (PD-004)*

Vinales (2015:532) argue that staff socialisation within the CLE is important and the sense of belonging of the student to the team is greatly dependent on the mentor. Thus, this sense of belonging develops into a mutual relationship, and its quality can have a significant impact on the mentoring process; either negatively or positively. For instance, it is easy to achieve a common goal if there is a reciprocal relationship as opposed to a relationship where there is one-way communication. Positive relationships in mentoring is a crucial factor that ensures success and professional development for both mentors and the students, as identified by Manister and Frederickson (2016). Similarly, in their study, Lawal et al (2016:34) also concluded that a positive interpersonal relationship is a key feature of effective mentoring that can be used as a strategy to promote learning.

4.3.3.2 Promotion of learning

Teaching and learning form part of the responsibilities of the mentors. Although most students gain experience through observation and are involved in patients' care, teaching and learning remain the best method to bridge the theory-practice gap(EL Hussein & Osuji 2017:23). In this study, teaching and learning were promoted through discussion, explanation, and demonstration as revealed by the participants.

> *"I usually discuss important cases which the students like to know and understand. I also ask a few relevant questions just to review what they have seen and learned in the ward...but all this is informal" (PC-003)*

> *"Advise them to review their theoretical notes on the procedures or nursing topics" (PE-005)*

> *"We also interact with each other through questions nurse I usually discuss with them and thus further explain on cases or topic of interest...this is a way to assess whether they are assimilating" (PD-004)*

"I usually call them around me whenever I am doing a procedure just to demonstrate how it is done so that they can do it by themselves...and I always supervise them when they are allowed to do it on their own" (PH-008)

Despite an attempt to promote learning, it was being done in an informal way as acknowledged by one of the participants (PC-003). This implies that nurses were not fully engaged in teaching and assessing students. Furthermore, there were no use of teaching strategies or application of learning theories. For instance the use of Benner's (1984), Kolb's (1984) or Grow's (1984) are critical to the professional development of students. Ideally, mentors should be conversant with the teaching methods and the learning styles of students. Moreover, learning does not take place unless the students are equipped with the necessary skills, attitudes, and knowledge. During the learning process in the CLE, the students tend to develop confidence, and this interaction provides an opportunity for the mentors to give feedback:

"this also provides opportunity for the mentor to give feedback and know what the students have learned in the unit and what they have missed" (PE-005)

Feedback has been identified as one of the key elements that mentors have to provide regularly as it helps in evaluating performance and assessing the competency of the students (RCN 2017). Burden (2017:1) further adds that feedback should be provided in a constructive way even if it is negative as its forms part of the clinical learning process. Thus, feedback allows students to build on their weaknesses for further improvement and mentors should document the progress of the student along the continuum of the training period.

4.3.3.3 Documentation

Within nursing, documentation is an important aspect of caring where treatments and interventions are mainly recorded in nursing notes. Documentation is central to mentoring as it provides a compilation of all observations, teaching and learning

activities which took place during students' clinical placement. It should be accurate, concise and comprehensive. In this study, two participants explained what formed part of students' documentation:

> *"At ward level, we simply sign a logbook in which all procedures they have recorded and done" (PE-005)*

> *"In fact, I always advise the students to keep a notebook to jot down all their observation regarding patients' cases, particularly new diseases" (PH-008)*

The recording of all clinical procedures in the logbook also attests that the students have been exposed to all the clinical procedures and the students' notebook serves as a reflective diary. Furthermore, it helps to identify what the students have not covered to close the theory-practice gap. Documentation is therefore crucial to the overall assessment of students' performance when it comes to mentoring. However, one participant pointed out that documentation was done in an incomprehensive way:

> *"but this is informal and nothing is recorded and is not similar to what educators teach at school" (PE-005).*

Documents used for assessment in clinical settings should be well designed, as emphasised by one participant:

> *"to monitor the progress of the students, proper assessment documents must be used" (PG-007)*

The use of documentation within nursing is crucial as it serves as an indicator with regards to comprehensiveness and clarity of any activity undertaken within the clinical setting (Alkhouri, Alkhatib & Khawafah 2016:104). With regards to clinical mentoring documentation is critical; however, it has been found that mentors commonly have difficulties properly recording practice assessment documents (Helminen et al

2014:1164). The use of appropriate assessment documents for the clinical evaluation of students allows the mentor to measure competence in a valid and reliable way to ensure pre-registration students are fit to practice (Cunningham et al 2015:266). It also ensures conformity and reduces subjective bias of the assessor (Helminen et al 2016:308).

4.3.4 Theme 4: Pre-requisites needed for the mentoring process

The fourth theme that emerged from the data focuses on the views of the participants with regards to improving the current mentoring system. Some pertinent points were suggested in response to this, and these will be elaborated on in the sections that follow.

4.3.4.1 The need for policy and directives for all stakeholders

The practice of mentoring in the local context is rather an informal one, as acknowledged earlier by the participants. Those involved in mentoring were not valued or recognised for their contribution. In response, participants suggested how the situation can be improved. The following quotes reflect participants' common views.

> *"there must be an agreed protocol between the school, the management and the regulatory body" (PD-004)*

> *"To me there must be a clear protocol what a learning environment need and this must be monitored to keep it standards" (PD-005)*

As noted previously, nurses who were involved in supporting students in the CLE were practising in isolation and in a vacuum since there was no clear direction from concerned authorities. These proposals made by participants are deemed relevant as it is anticipated that all stakeholders will align themselves towards a common goal. A comprehensive protocol in a mentoring system would likely create awareness among

nurses and ensure commitment and support to mentors. The importance of guidance and support to mentors are well documented.

Hence, the proper coordination between training institutions and practice settings is likely a key measure that gives direction to mentoring (RCN 2015). To further maximise learning in practice, successful working relationships, patience, time and effort are important on the part of the mentors and students (Houghton 2016:47).

4.3.4.2 Collaboration between stakeholders

Within the health system, all health professionals involved in the care of patients are interdependent and usually work as a multidisciplinary team. It is a common fact that training institutions involved in the training of nurses seek input from other health professionals in the context of a collaborative effort. As discussed earlier, nurses supporting students were self-reliant since they had to manage on their own. Participants felt that collaboration among key stakeholders was important to sustain a good mentoring system. The following quote is representative of participants' expressions

> *"I believe it will be important to have the collaboration of the training institution, the nursing trade unions and the regulatory body to decide on a mentoring system which is adaptable to our context." (P-007)*

This confirms that the current mentoring system received poor attention. In their study, Cunningham et al (2015:257) also emphasised that successful clinical education is reliant on the availability of adequate resources, but collaboration between training institutions, clinical placements and students is essential. However, a firm commitment from all stakeholders, including the management and the students, are pivotal. For instance, regular meetings can be organised, and proper planning and negotiations of the way forward can take place, as suggested by one participant

"There must be good planning regarding students placement…and the ward manager must arrange a meeting with them" (PE-005)

It can also be argued that concerning mentoring, collaboration encompasses coordinating, planning and leading. Furthermore, collaborative approaches facilitate the sharing of knowledge, expertise, and resources, while a common vision and goals are developed as well (Rakhudu, Maselesele & Useh 2016:2). The challenges facing nursing education in an ever-changing healthcare environment require interdependence of inputs from all resources to optimise learning (Direko & Maselele 2017:3). Likewise, Harvey and Uren (2018:38) recommend a collaborative mentorship model where first, second and third-year students are assigned to patients' care under supervision with the support of mentors, nurses, and educators. This suggests that the responsibilities of the stakeholders are crucial in clinical education, and collaboration is considered an important aspect of clinical training.

4.3.4.3 Training of mentors: A short course

Participants in this study acknowledged that they learned in the field and from their seniors without having undergone any training. They also recognised that this was a major shortcoming in the mentoring system, particularly in the context of the new DGN students who started. The need to train mentors was raised by nearly all participants. The following quote reflects the views of all participants.

"In fact, those who are involved in mentoring should have special training in mentoring and hold a relevant qualification…One of the fundamental qualities of the mentor is teaching with good communication skills" (PA-001)

According to the participants, the core content of the programme should be based on teaching and assessing:

"I think the central focus must be on teaching, assessing and understanding the content of curriculum…be clinically skillful…teaching skills will matter a lot" (PD-004)

Likewise, participants also stated that mentors should have leadership and managerial skills:

"they should have leadership and managerial skills to solve students' problem" (PB-002)

"There should be a commitment from collaborators...and this requires leadership qualities from the mentor, the ward manager, and the educators...that's all" (PC-004)

Mentoring students is directly linked to training and education. It is therefore understood that the mentors should be conversant with the pedagogical aspects regarding education and training. This will certainly help them in developing the necessary skills, aptitudes, and competencies to assume their role as mentors, particularly in terms of teaching and assessing. The training of mentors has been found to have a positive impact on students, nurses and the organisation if there is rigorous selection among nurses and adequate training (Zhang, Qian, Wu, Wen & Zhang 2014:136). Teaching and assessing in CLE have been identified as core skills among mentors (De Abreu & Interpeller 2015:45), while mentorship programmes require a multitude of teaching strategies, frequent updates and long-term development(Chen & Lou 2014:442).

Although the literature on mentoring does not mention leadership as a quality, it would seem instrumental for the profile of the mentor, owing to his broad responsibilities. The statements on leadership correspond with the findings of Papastavarou et al (2016:45), which also reported that the leadership style of key stakeholders is an influential factor in mentoring. This view is also upheld by the RCN (2015) in its report, which highlighted that strong leadership is required for mentorship to face current challenges at all levels.

In addition to these skills, participants also emphasised other qualities a mentor should have, as reflected in the following quotes:

> *"The mentor must negotiate with the administration not to shift students to other units during their placement" (PA-001)*

> *"the ward manager must do good planning regarding students placement and inculcate a learning culture to all the staff" (PA-001)*

> *"but the mentor must always motivate them and explain what is expected from them" (PG-007)*

It can be argued that for a mentor to be recognised as being competent, he has to develop certain skills and qualities. However, participants emphasised a range of skills of the mentor, such as negotiating, motivating or planning, as well as teaching, interpersonal, managing and leadership skills. Someone is deemed competent when he or she is able to demonstrate the required skills, knowledge, performance and attitude to perform a task to an acceptable and agreed standard (Tuomikoski & Kaariainen 2016:99).

4.3.4.4 Clinical setting requirements

The clinical setting is also referred as the CLE and is an important cornerstone of nursing education since it is perceived by students as the environment where they acquire skills and knowledge to become professional nurses (Neupane, Pandey & Sah 2018:37). The clinical setting was recognised as an essential element that shapes the professional growth of both students and staff as pointed out by one participant:

> *"It is the clinical setting which provides opportunities for both students and staff to learn and grow professionally" (PD-004)*

Clinical setting in itself is complex; in fact, it provides learning opportunities for all staff while allowing health professionals to practice along with caring for patients. It also has constraints, such as shortage of staff and the lack of other resources. The ward manager, therefore, has to assist the mentor in maintaining a conducive CLE, where the focus is on skills acquisition, development of competencies and proficiencies of student nurses, as Vinales (2016:50) puts it. Hence, clinical settings that are poorly equipped are likely to impact on both patients' care and students' learning. One participant rightly concluded that:

> *"mentors should be allocated enough time to support students...I also think that there must be sufficient equipment, adequate staffing, and other learning resources" (PF-006)*

Thus, the points mentioned reflect the real challenges faced by the mentors in the CLE. Similar findings have also been reported in other studies (Anarado et al 2016:19; Dlama et al 2016:57). Concerns were raised by participants regarding one pertinent point common to both students and mentors, as illustrated in the following quotes:

> *"it is also important to decide on the number of students a mentor can take under his responsibility...that is the mentor /student ratio" (PG-007).*

> "*it must be clear how many students a ward can accommodate and the student mentor ratio must be decided so that proper attention can be given to all the students" (PD-004)*

The absence of a clear protocol regarding the ratio of mentors to students indicates that the mentor has to support students in the ward irrespective of the numbers. This poses a problem, particularly when one mentor has to manage and give individual attention to the students. Although the NMC (2008) advocates a ratio 1:1, it is now considering reviewing this model of mentoring with less focus on the ratio 1:1 (RCN2015). The ratio is likely to be influenced by the ward capacity, and the number of mentors and students

posted in the CLE. In other words, it will be contextual depending on available resources. In other European countries, mentors are exclusively posted in wards to support students, and the ratio is usually 1:5 (Papastavrou et al 2016:45).

4.3.4.5 The role of the mentor

The role of the mentor is broad and relates mainly to caring for patients and clinically supporting students. It varies according to context. But at its most basic level, mentors are required to guide, supervise and advise students. Mentors have to fulfil their roles within the continuum of caring and supporting students. Despite the mentors' broad responsibilities, Greenfield argues (2015:29) that they should primarily focus on supporting, teaching, supervising and assessing students. In this study, participants revealed what was specific to their roles as mentors. The following quotes represent the general views of participants

> *"I also encouraged them to observe and assist staff when nursing procedures are being carried…I usually allowed them to perform small procedures under guidance and supervision" (PC-003)*

> *"I usually guide, observe and monitor their performance" (PC-004)*

This indicates that the participants were not involved in formal teaching and assessing and, as such, it is a gap within the mentoring system. As discussed earlier, what participants had been practising was similar to clinical accompaniment rather than mentoring. It therefore follows that there is no appropriate mechanism in place to evaluate students for their fitness to practice.

> *"This is because of the trust and confidence which the mentors and other nurses had on them during their training...in brief, he should meet the expectations of the students and be a role model" (PC-003)*

"This also provides an opportunity for the mentor to give feedback…He should command respect from all staff and be trustful as well" (PF-006)

Participants were also of the view that there should be full-time mentors in clinical settings:

"new posts should be created for them so that they can be employed on full time basis" (PD-004).

"I think the students will benefit a lot and will not feel neglected if management can give special responsibility to nurses to look after the students who are on placement" (PF-006)

The daily presence of full-time mentors implies mentors will have adequate time to devote to students; in fact, they will not be involved in patients' caring. This will also ensure better follow-up on the progress of all students and the maintenance of a conducive CLE. In essence, mentors' roles appear multifaceted and their personal qualities and character are the hallmark of mentoring (Sabog et al 2015:5). Nonetheless, there are converging views that good mentors should be able to teach effectively, have clinical competencies and sound interpersonal skills (Bvumbwe et al 2015:924; Rajeswaran 2016:1).

4.3.4.6 The responsibilities of the students

In a mentoring relationship, there is a shared responsibility between the mentor and the student, despite the mentor having a dominant role to lead the student. In this study, willingness to learn and empowerment of students were two important points highlighted by participants as illustrated in the following quotes

"The students must be encouraged and empowered…I think there must be a willingness on the part of the students to do their best to learn and be proactive" (PB-002)

"If the students want to be fit for practice they must always show their willingness to learn and practice" (PF-006)

There are many challenges which students encounter during their placement and they should be empowered to face them. This tends to instil a sense of confidence to make them more independent and take their responsibilities seriously. This is not achievable unless there are willingness and motivation from the students to learn and practice. However, students should also ensure that they are under supervision when performing any clinical procedure or when providing care to patients, and take responsibility for their professional development. Although there are many responsibilities which students can shoulder, some key responsibilities include theoretical knowledge in the area of practice, awareness of the training programmes and its learning outcomes, and compliance with codes of practice and ward policies (RCN 2017). In their study, Baraz et al (2015:53) found that the main challenges experienced by students relate to untrained mentors, unsupportive CLEs, and educational objectives which are not met. These also reflect the local context. Therefore, the students have an interest to be proactive to overcome those challenges with the help of the mentor.

4.5 SUMMARY

The four main themes that emerged from the findings represent the gap in the actual mentoring system. The findings confirmed that students' learning in clinical settings was in the form of clinical accompaniment and was done informally. Moreover, the participants acknowledged they were not recognised as mentors since they were untrained. This indicates they are a novice in the field of clinical mentoring; they did not have new knowledge or skills regarding clinical mentoring, they did not have the required knowledge or skills regarding clinical mentoring, and were self-reliant for their

role and training. The participants reported that supporting students was a routine task and found themselves in the dual role of a nurse and a mentor. This suggests that full support was not given to students and the nurses themselves would need to be guided and supported to progress from novices to becoming expert clinical mentors.

This chapter has outlined and presented the qualitative analysis of Phase 1 of the study. A thematic analysis was used for the data analysis, and the findings were illustrated through quotes, as reported by participants. These quotes were given meanings through codes, categories and finally grouped into four main themes. The four emerging themes were intertwined and included; mentoring in the form of accompaniment, a variety of activities/roles are described in everyday clinical practice, aspects of mentoring found present and pre-requisites needed for the mentoring process. It was found that the absence of clear policy regarding mentoring in the local context has led to the lack of support of students in the form of clinical accompaniment. The term 'mentoring' was variously described by participants, which support the fact that there is no clear definition of mentoring. Teaching, assessing and leadership were found to be important competencies for the mentor. Despite some aspects of mentoring being noted, participants acknowledged that key pre-requisites for mentoring is a training programme with an emphasis on teaching. Finally, this phase of the study demonstrated that the objectives and research questions of the study are grounded in the four themes.

The findings of this phase formed the basis of the second phase of the study, particularly the design of the data collection tool. The next chapter presents the findings, analysis, and discussions of the quantitative phase.

CHAPTER 5
QUANTITATIVE ANALYSIS, RESULTS, AND DISCUSSION OF PHASE 2

5.1 INTRODUCTION

This chapter focuses on the analysis, results, and discussion of Phase 2of the study. The objectives of this phase were to investigate the current clinical mentoring practices from both qualified nurses' and students' perspectives. These were used to compare the current clinical mentoring practices as perceived by qualified nurses and students, to determine whether the current clinical mentoring system responds to the practice learning needs of the DGN programme.

In line with the quantitative phase of the study, a structured questionnaire was used to collect data. Data were collected from third-year students and qualified nurses who were acting as mentors. This sample population was considered to capture a holistic view of the phenomenon under study. A random sample was used and the sample size for the students was 115 (n=115) and that for nurses was 255 (n=255). The designs of the questionnaires were based on the findings of Phase 1 of the study and relevant literature. The content of the data collection tools for both students and nurses were nearly identical with slight differences regarding the number of items. Both questionnaires were divided into three sections; namely Section A, with background information, Section B, relating to the current practice of mentoring, and Section C, concerning the CLE. The content of the questionnaires was aligned with the aim and objectives of the study. Data analyses were conducted using the computer software SPSS 21.0, and both descriptive and inferential statistics were used. These will be presented and supported with tables and bar charts along with discussions in the sections that follow.

5.2 SECTION A: BACKGROUND INFORMATION

This section provides an overview of the findings related to Section A of the two questionnaires. For the sake of clarity, both results will be presented and described concurrently. The variables under this section were mainly related to gender, age, occupation, level of education and experience.

5.2.1 Gender of participants

Figure 5.1 shows the gender of the respondents. In this study, 52.0% (n=60) of the students were males, while 48.0% (n=55) were females. Similarly, 54.0% (n=138) of the nurses were males and 46.0% (n=117) were females. As noted, in the local context the majority of respondents in the two samples were males. This draws from the fact that recruitment for the past 10years has seen an increasing number of males joining the profession and more female nurses than males have retired (MOH & QOL 2016).

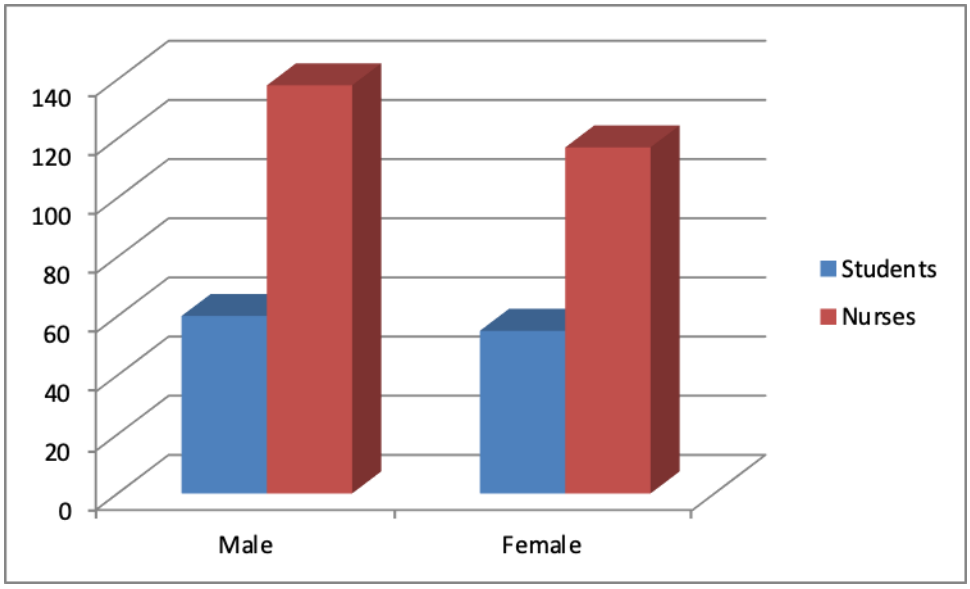

Figure 5.1: Gender of participants, students (n=115) and nurses (n=255)

5.2.2 Age group of participants

The age group of the respondents is illustrated in Figure 5.2. A majority of the students (87.8%; n=101) were in the age group of 20-30 years. In contrast, 34.9% (n=89) of nurses were in the age group of 36-40 years, followed by 26.7% (n=68) who were above 50 years, then 20.4% (n=52) who were between 46-50 years, and lastly 18.0% (n=46) who were in the age group of 41-45 years. Overall, nearly all the nurses had at least 15 years of clinical experiences, implying that they were conversant with the local mentoring system.

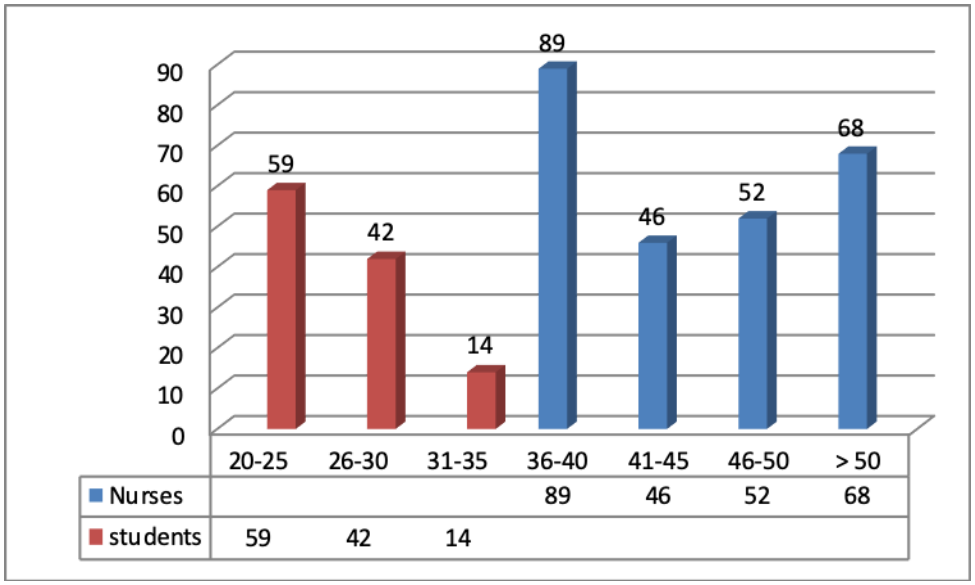

Figure 5.2: Age of participants, students (n=115) and nurses (n=255)

5.2.3 Level of education, students and nurses

The level of education and professional qualifications of both students and nurses are depicted in Figure 5.3. Almost all students (98.3%; n=113) have obtained a high school certificate. Some participants also held post-secondary qualifications. For instance, 10.4% (n=12) had completed a Diploma, while 23.5% (n=27) held a degree. Of the student sample, 75.3% (n=192) had a higher school certificate, while only 24.7% (n=63), held a basic school certificate.

A majority of the nurses (94.5%; n= 241) had a DGN, while only 5.5% (n=14) had a degree in general nursing, a few nurses (5.1%; n=13) were enrolled in a part-time course for their professional development, compared to 94.9% (n=242) who were not following any course. The non-inclusion of nursing programmes offered at university level in the local context is considered a major barrier for nurses to further their professional development as highlighted by the Human Resource Development Council (2015).

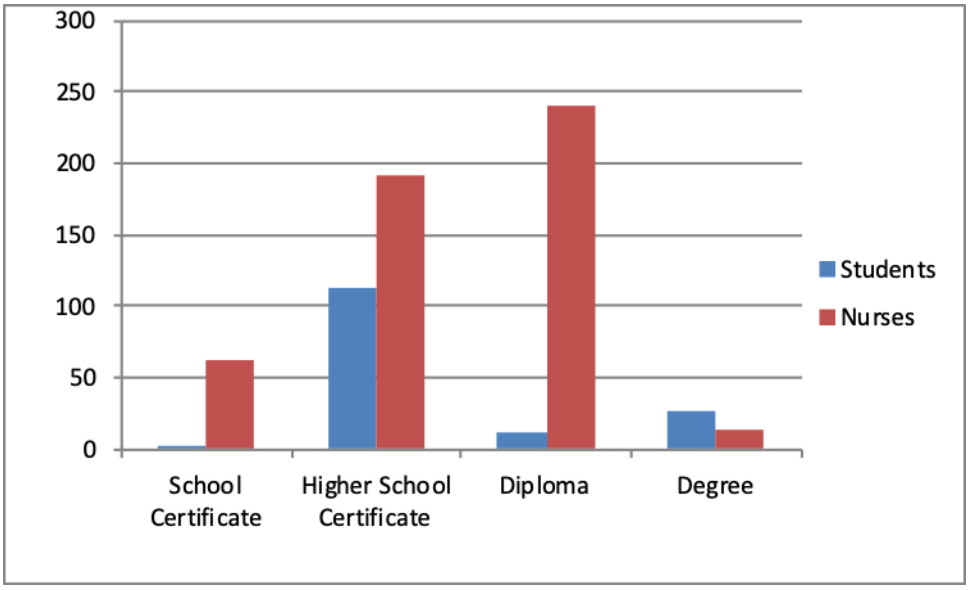

Figure 5.3: Levels of education and professional qualifications

5.2.4 Practical placements of students and posting of nurses

Above 90% (n=>100) of the students in this study had completed all their clinical placements as summarised in Figure 5.4. All the important units were covered, including medical, surgical and orthopaedics. This also included sub-speciality areas such as intensive care units, neurosurgery, cardiac, accident and emergency departments, paediatrics, dialysis, psychiatry, obstetrics and gynaecology. All the student respondents were also exposed to specialised units such as ophthalmology, ear nose and throat divisions, burn units, and radiotherapy. This indicates that as pre-registrants, the students were rotated in all clinical placements to improve their fitness to practice.

The clinical placements provide students with real practice situations to enhance their skills. Clinical placement is, therefore, an integral part of the nursing curriculum which allows students the opportunity to practice and achieve professional competence (Bvumbwe et al 2015:927).

With regards to nurses, they were posted in all clinical settings where students were on placement, as shown in Table 5.4. It is to be noted that the majority of respondents were posted in general wards such as medical, surgical and orthopaedics. Some were posted in speciality units as well, such as coronary care, intensive care, operation theatres, neonatal care, and accident and emergency departments. This suggests that students could potentially receive or have access to some kind of learning support throughout their practice placements. However, clinical placement should also consider community settings which have proven to be positive learning experiences for pre-registration students (Peters, McInnes & Halcomb 2015:175).

As illustrated in Figure 5.4, there was a significant student to nurse ratio across all clinical settings. This implies that there were always more students than nurses in the wards, which also raises the question as to whether all students were given due attention in terms of their learning support. This corroborates with what was stated by participants in Phase 1 of the study; that there was inadequate staff to support students' learning in the wards. Despite this constraint, the mentor and student relationship have likely been maintained. Nonetheless, it is the strength of the relationship between the training institution and the clinical placement which influences students' progress (Mercia 2016:2).

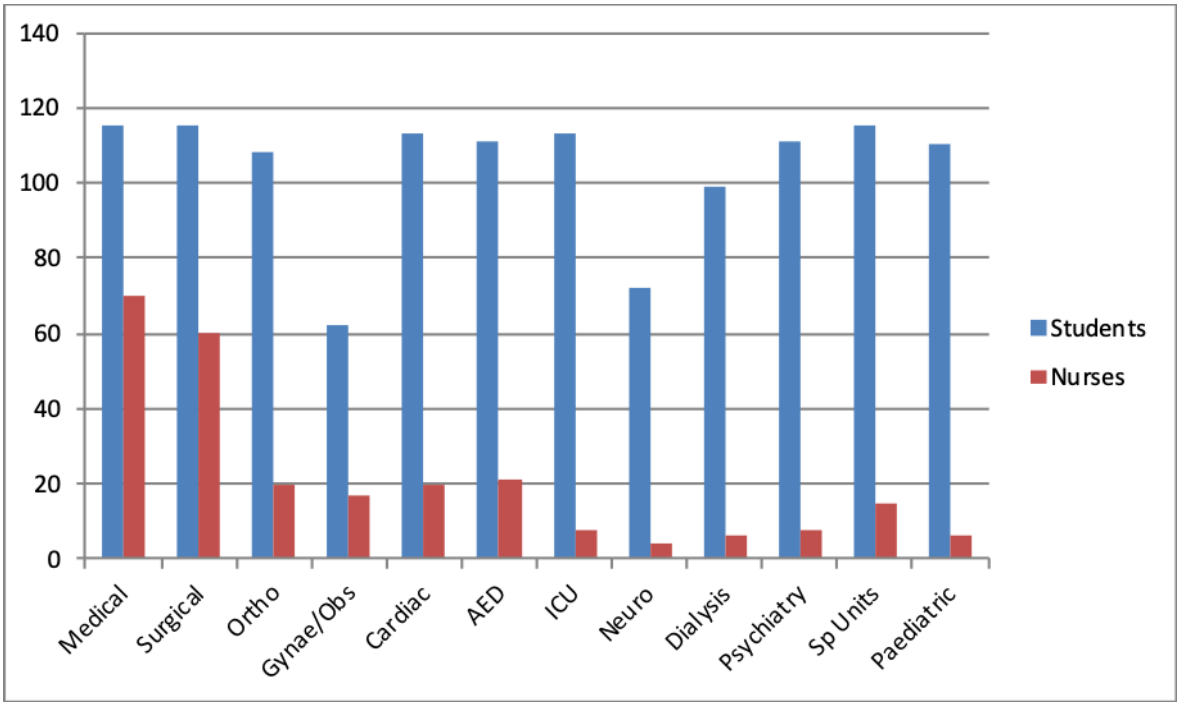

Figure 5.4: Placement of students (n=115) and posting of nurses (n=255)

5.2.5 Current position and length of service of nurses

Table 5.1 illustrates the nurses' current position and length of service. The majority of the respondents were nurses (63.1%; n=161), followed by charge nurses (26.3%; n= 67) and ward managers (10.6%; n=27). With regards to the length of service, half of the respondents (50.2%; n=128) had a length of service between 16-25 years, while 34.5% (n=88) had above 25 years. This is summarised in Table 5.5. This indicates that some respondents had extensive experiences in their area of practice, particularly the charge nurses and ward managers, which also matches the profile of the participants in Phase 1 of the study. The range of years of service also indicates that the nurses had full experience in their field. Although they were not experts in the field of mentoring, per se, they might be considered as being advanced beginners with competence, as pointed out in Benner's (1984) Novice to Expert Model. It is also to be noted that around 34.5% (n=88) of the respondents had above 25 years of service. These respondents were either reaching retirement age or nearing retirement. This demographic profile of the

respondents also reflects the global trend of an ageing nursing workforce as highlighted in the medical and health statistics annual (MOH & QOL 2016).

Table 5.1: Current position and length of service of nurses

Current position	Length of service				Total
	>15years	16-20 years	21-25years	>25years	
Ward Manager	0	0	0	27	27
Charge Nurse	0	0	13	54	67
Nursing Officer	39	94	21	7	161
Total	39	94	34	88	255

5.3 SECTION B: CURRENT PRACTICE OF MENTORING

Data from this section of the two questionnaires provide insight into how the current practice of mentoring was viewed from both nurses' and the students' perspectives. The figures and tables presented hereunder have been reproduced from the raw data generated by the statistician. Emphasis is placed on the main highlights of the findings from both questionnaires, which are interpreted in frequencies and percentages and discussed accordingly.

5.3.1 The practice of mentoring

Both students and nurses were asked whether there was a mentoring system in place to support students' learning, the frequency at which mentoring took place, and if they considered it formal or informal. The main findings are illustrated in Table 5.2.

Table 5.2: The practice of mentoring. Nurses (n=255), Students (n=115)

		Nurses	Students
Mentoring system	Yes	44.0%(n=114)	7.0% (n=8)
	No	53.7%(n=137)	76.5%(n-88)
Frequency of mentoring	Frequently	18.4%(n=47)	4.3%(n=5)
	Occasionally	36.9%(n=94)	11.3%(n=13)
	Sometimes	29.4% (n=75)	31.3%(n=36)
	Rarely	15.3% (n=39)	53.0%(n=61)
Formal or informal	Formal	20.8%(n=53)	2.6%(n=3)
	Informal	31.0%(n=79)	26.1%(n=30)
	Both	36.1%(n=92)	27.8%(n=32)
	Uncertain	12.2%(n=31)	43.5%(n=50)

A very low 7% (n=8) of the students stated that there was a mentoring system in place, as opposed to 44% of nurses (n=114). Slightly more than half of the nurses (53.7%; n=137) and a high percentage of 76.5% (n=88) of the students were of the view that no mentoring system was in place. With regards to the frequency of mentoring, 18.4% (n=47) of the nurses affirmed that they were frequently mentored, while only 4.3% (n=5) of students revealed they were frequently mentored, and 53%(n=61) answered that they were rarely mentored. Only 20.8% (n=53) of the nurses and a low percentage of students (2.6%; n=3) considered the mentoring system to be formal. The mentoring practice was also seen as informal (31.0%; n=79) and both formal and informal by nurses 36.1% (n=92). In contrast, around 12.2% (n=31) of nurses and 43.5% (n=50) of the students were uncertain whether the mentoring was formal or informal.

These findings correspond to the first main theme of the qualitative phase of the study and its categories as discussed and shown in Table 4.2, namely "*Mentoring as per definition is not practiced but rather a form of clinical accompaniment resulting in the practice being less effective for (its) purpose"*. Two important points that raise concern relate to the number of nurses (n=79) who considered that mentoring was both formal and informal, along with the number of students (n=50) who were uncertain as to

whether it was formal or informal. This indicates that mentoring is still not being clearly understood, and the roles of nurses who support learning were not properly defined. Indeed, formal mentoring is planned and structured according to Green and Jackson (2014:79). Participants in Phase 1 of the study confirmed they were not recognised as mentors and the mentoring system was informal. This also reflects the views that formal mentoring involves a recognised relationship, where the mentor is assigned to a student as agreed by concerned stakeholders (Oluchina & Gitonga 2016:23).

5.3.2 Involvement in mentoring, learning needs, educators visits and students ratio

Students' and nurses' views were sought with regards to their participation in mentoring, their learning needs, educators' visits and students' ratio. These responses are illustrated in Table 5.3. An average of 20.0% (n=52) of the nurses were mentoring students either often, frequently, occasionally, sometimes, or rarely. Similarly, an average of 20.0% (n=24) of the students was involved in peer mentoring. This denotes there is some degree of constant learning support for students despite the low percentage noted among both nurses and students, while it is also evident that the majority of the nurses were not fully engaged in mentoring. Less than fifty percent (45.1%; n=115) of the nurses pointed out that their learning needs were met to a small extent, and (15.7%; n=40) to a very small extent. In contrast, 25.2% (n=29) of the students stated that their learning needs were met to a small extent, 25.2% (n=29) were uncertain, while 38.3% (n=44) affirmed that it was to a very small extent.

Table 5.3: Involvement in mentoring, learning needs educators' visits and students' ratio. Nurses (n=255), Students (n=115)

		Nurses	Students
Involvement in mentoring	Often		20.9% (n=24)
	Frequently	29.4% (n=75)	27.0% (n=31)
	Occasionally	20.4% (n=52)	21.7% (n=25)
	Sometimes	23.5% (n=60)	17.4% (n=20)

		Nurses	Students
	Rarely	26.7% (n=68)	13.0% (n=15)
Learning needs	To a great extent	23.9% (n=61)	11.3% (n=13)
	To a little extent	45.1% (n=115)	25.2% (n=29)
	Uncertain	15.3% (n=39)	25.2% (n=29)
	To a very low extent	15.7% (n=40)	38.3% (n=44)
Educators visits	Frequently	2.7% (n=7)	0.9% (n=1)
	Occasionally	12.5% (n=32)	9.6% (n=11)
	Sometimes	13.3% (n=34)	3.5% (n=4)
	Rarely	40.8% (n=104)	15.7% (n=18)
	Never	30.6% (n=78)	70.4% (n=81)
Students ratio	1:1	26.3% (n=67)	10.4% (n=12)
	1:5	55.7% (n=142)	67.8% (n=78)
	1:10	16.1% (n=41)	11.3% (n=13)
	1:15	2.0% (n=5)	10.4% (n=12)

A very low 2.7% (n=7) of nurses and 0.9% (n=1) of students stated that they frequently receive educators' visits. However, 40.8 % (n=104) of nurses also added that educators rarely visit their wards compared to 30.6% (n=78) of nurses, and 70.4% (n=81) of students affirmed that educators never paid a visit to students during their placement. There was a convergence of views with regards to mentor-student ratios, since above fifty percent of nurses (55.7%; n=142) and students (67.8%; n=78) believed that the ratio should be 1:5.

The lack of involvement of the majority of the nurses in terms of mentoring students indicates that not all students were receiving the necessary learning support from their seniors. It was also observed by participants in Phase 1 of the study that many nurses were not engaged in mentoring. One participant shared *"with time many qualified nurses are reluctant to supervise students during their placement".* This would likely result in the learning needs of students being unmet.

However, the students' attempts to engage in peer mentoring is a laudable effort as it promotes close collaboration, critical thinking, and confidence (Joubert & De Villiers 2015:1) while improving positive learning and service outcomes (RCN 2015). The claim by students (n=81) that the educators never visited them is a major concern, as this tends to point to the fact that the quality of clinical training is not upheld. This shortcoming was also raised earlier during the first phase of the study, where participants reported that no monitoring took place at the school regarding the theory-practice gap when students were on placement. The study of Maxwell et al (2015:36) emphasised the importance of a training institution providing support to both the mentor and mentee to optimise their practice experience. The authors referred to the practice educator who ensures a link between the training institution and the clinical settings.

The students' ratio of 1:5 was seen as acceptable by both nurses and students. This is in line with the European standard as stated by Papastavrou et al (2016:45). Also, it was confirmed by all nurses (100%; n=255) that they did not attend any seminars on mentorship in the past three years. This is in contrast with the mentoring process which requires mentors to undergo a training programme for capacity building, empowerment and professional development (Seekoe 2014:137). Moreover, every mentor should stay current by updating their knowledge through continuous professional development to better respond to the individual needs of the students and the service (National Health Services (NHS) England 2016).

5.3.3 Nurses as mentors, separate career, professional development, and job satisfaction

Respondents in this phase of the study were also asked whether all nurses should become mentors, or whether mentoring should be considered as a new career pathway with regards to professional and job satisfaction. The responses to these variables are summarised in Table 5.4.

Table 5.4: Nurses as mentors, separate career, professional development, and job satisfaction. Nurses (n=255), Students (n=115)

		Nurses	Students
Nurse as mentors	Yes	58.2% (n=149)	53.9% (n=62)
	No	36.9% (n=94)	20.0% (n=23)
	Uncertain	1.2% (n=3)	10.4% (n=12)
	May be	3.5% (n=9)	15.7% (n=18)
Separate career	Yes	48.2% (n=123)	63.5% (n=73)
	No	25.5% (n=65)	18.3% (n=21)
	Uncertain	15.3% (n=39)	5.2% (n=6)
	May be	11.0% (n=28)	13.0% (n=15)
Professional development	Yes	83.9% (n=214)	73.9% (n=85)
	No	0.8% (n=2)	2.6% (n=30)
	Uncertain	11.4% (n=29)	13.9% (n=16)
	May be	3.9% (n=10)	9.6% (n=11)
Job satisfaction/staff retention	Yes	74.1% (n=189)	
	No	9.8% (n=25)	
	Uncertain	11.4% (n=29)	
	May be	4.7% (12)	

More than half of the nurses (58.2%; n=149) and students (53.9%; n=62) agreed that all nurses should act as mentors, while 36.9%(n=94) of the nurses and 20.0% (n=23) of the students were of the view that not all nurses should act as mentors. Less than half of the nurses (48.2%; n=123) and more than half of the students (63.5%; n=73) considered that mentoring should be a separate career pathway. A majority of the nurses (83.9%; n=214) and students (73.9%; n=85) believed that mentoring contributes to shaping their professional development. Nearly three-quarter of the nurses (74.1%; n=189) reported that mentoring is also associated with job satisfaction and staff retention.

Participants in Phase1of the study felt they were unprepared to take the role of the mentor as they were not trained. They further reported that the dual role as a carer and mentor, along with the lack of training and non-designation as mentors were a barrier to the effective practice of mentoring. This also impacts on Benner's (1984) Novice to Expert continuum where the learner's progress might be severely compromised. Additionally, one should be conversant with the learning outcomes of the programme (RCN 2017).In this phase of the study, both students and nurses stated that all nurses can act as mentors. This view is also shared by participants in the first phase of the study, but they acknowledged that mentors need some kind of training as mentioned by one participant "*it will be difficult to practice mentoring as in the UK because Mauritian nurses are not trained to be a mentor*". While all nurses have the potential to become mentors, the quality of mentoring can suffer if they do not have an interest in education (King's College 2013). Furthermore, assessing the competence of students requires clinical experience with knowledge of learning and teaching. To that end, the pedagogical development of those nurses as mentors can be based on the five stages of Benner's (1984) Novice to Expert Model by undergoing relevant training, while starting as a coach, acting as motivator and facilitator to eventually become the consultant (Grow1991). Rajeshwaran (2016:471) referred to mentoring as clinical learning with challenges that are absent in a classroom, requiring mentors who are trained.

Participants in the first phase of the study believed that nurses interested in mentoring should be allowed to train as mentors and be promoted to full-time mentors. Other studies (Horner 2017:7; King's College 2013) have also reported similar findings; that is, mentoring as a new career pathway could attract more nurses as mentors thereby leading to retention and job satisfaction.

5.3.4 Mentors' training, skills, standards and failing students

The mentor's scope of practice requires certain skills, maintaining standards and objectively assessing low performing students. The responses to these variables are depicted in Table 5.5.

Table 5.5: Mentors' training, skills, standards and failing students. Nurses(n=255), Students (n=115)

		Nurses	Students
Mentors' training	Yes	86.3% (n=220)	91.3% (n=105)
	No	2.7% (n=7)	3.5% (n=4)
	Uncertain	1.6% (n=4)	0.9% (n=1)
	May be	9.4% (n=24)	4.3% (n=5)
Standards in mentoring	Yes	74.5% (n=190)	93% (n=107)
	No	2.0% (n=5)	0.9% (n=1)
	Uncertain	5.9% (n=15)	2.6% (n=3)
	May be	17.6% (n=45)	3.5% (n=4)
Failing students	Yes	35.3% (n=90)	
	No	36.9% (n=94)	
	Uncertain	14.9% (n=38)	
	May be	12.9% (n=33)	
Mentors' skills	Leadership skills		42.6% (n=49)
	Counselling skills		61.7% (n=71)
	Teaching skills		88.7% (n=102)
	Managerial skills		26.1% (n=30)
	Interpersonal skills		71.3% (n=82)

A majority of the students (91.3%; n=105) and nurses (86.3%; n=220) stated that mentors should be trained and hold an appropriate qualification. Similarly, 74.5% (n=190) of nurses and 93.0% (n=103) of students believed that the current mentoring system needs to be reviewed to uphold its standards. Likewise, there were diverse views among nurses as to whether they would fail students. This normally refers to those students who are low performers and have not been able to achieve the required level of competence. Of the nurses, 35.3% (n=90) affirmed they would fail students, 36.9% (n=94) said they would not, while 14.9% (n=38) were uncertain. The three most important skills which the students identified were teaching skills (88.7%; n=102), followed by interpersonal skills (71.3%; n=82) and counselling skills (61.7%; n=71).

Respondents in this phase of the study were unanimous in their opinion that those involved in mentoring should have undergone training in mentorship. This is consistent with the findings of Phase 1 as pointed out by one participant "*Mentoring of students should be assigned to trained mentors who have followed a course on mentoring".* This implies that they should hold a specific qualification. In other words, they should be knowledgeable and competent to fit in the role of the expert (Benner 1984) and the consultant (Grow 1991). In accordance with this, the recruitment process of mentors should ensure they have a set of skills and competencies to fulfil their role effectively as a mentor in the context of practice-based education (RCN 2015). Moreover, a trained mentor is more conversant with the evaluation process and the giving and receiving of feedback, which allows nurses to better understand their roles and why they are assigned a mentor (Kourtney 2016:13).

Likewise, the participants found teaching as one of the key skills which mentors should possess among other desired skills, like counselling, leadership, interpersonal and managerial skills. This also reflects what was suggested by participants in Phase 1 of the study, and is consistent with the findings of other studies. One of the fundamental qualities of the mentor is teaching with good communication and interpersonal skills. Conversely, teaching, supervising and assessing are considered to be the three most important elements to describe the role of the mentor (NMC 2008; RCN 2015). Many authors (Sabog et al 2015:5; Sand et al 2015:1-7) have pointed out that learning in clinical settings takes place when the mentor applies their teaching skills. Although teaching is an important skill, the mentor should also be competent. This implies they should be knowledgeable and skilful, have values and attitudes, and perform according to standards (Tuomikoski & Kaariainen 2016:100). However, in addition to developing competencies other than teaching, participants in Phase 1 also considered leadership an important competency. This is in line with the NMC (2008) requirements which consider leadership as a core competency to be met by prospective mentors. Conversely, in its transformative lifelong learning process, mentorship has also been recognised as an influential factor which motivates nurses to become leaders

(McCloughen, O'Brien & Jackson 2014:301). In addition, the assessment of students remains a key undertaking for mentors.

Assessment of clinical competence of the students forms part of the responsibilities of the mentor (Benette & McGowan 2015:454; Douglas et al 2016:34; NMC 2008). In their study, Benette and McGowan (2015:454) also reported that mentors are not prepared and lack confidence to conduct assessments. Similarly, participants in Phase 1 of the study also reported that they were not prepared to undertake assessments. In this study, only 35.3% of the participants stated that they would fail poor performers, which implies that the majority would either hesitate or let go of the poor performers. It would seem failing students is a sensitive issue which places the mentors in a dilemma. Alternatively, one way of overcoming this problem is to devise strategies, such as the use of assessment tools, understanding learning outcomes and assessment criteria, and promoting a consultative role between the students, mentors and the educators (Baumgartner et al 2017:121). The authors also pointed out that an assessment process should include all the mentioned elements.

According to the responses from Section B of the questionnaires, there was a convergence of views on key issues regarding mentoring. This includes the mentor to student ratio, the need to maintain standards regarding mentoring practice, and that mentors should be trained and hold an appropriate qualification. This matches the views of participants in Phase 1. Likewise, there were opposing views with regards to other important aspects of mentoring. For instance, students (76.5%; n=88) believed that there was no mentoring system in place compared to nurses (53.7%; n=137). Only 36.9% (n=94) of nurses stated that they occasionally mentored students, contrary to students (53.0%; n=61) who responded that they were rarely mentored. Similarly, the learning needs were seen to be met to a small extent by nurses (45.1%; n=115) and to a very small extent by students (38.3%; n=44). Moreover, nurses (40.8%; n=104) added there were rare visits of educators to the wards in contrast to students (70.4%; n=81) who stated educators never visited their wards.

These findings confirm that there was no uniformity in the current practice of mentoring in clinical settings. This also reflects what was identified in the findings of Phase 1 of the study under the categories "*lacks of policy directives and standards"* and *"current activities are informal"* (Table 4.2). Thus, the first objective and its relevant research question have been addressed in the presented discussion of Section B of the questionnaires.

5.4 SECTION C: CLINICAL LEARNING ENVIRONMENT

This section of the questionnaire focused on factors that tend to influence the CLE. It consisted of Likert style scaled responses with a scale of 0-5, ranging from strongly disagree to strongly agree. These factors were categorised accordingly under four headings. This included ward organisation with 12 items, communication and relationship with 13 items, mentoring with 22 items, and barriers to effective mentoring with 16 items. The total number of items was the same for both nurses and students. Measures of means and standard deviations were used to quantify the variation within the data set. One-sample t-test was performed to establish if there is a difference between the nurses' and students' perceptions of the factors that influence mentoring in the CLE. The overall responses of the CLE are presented and discussed separately in the sections that follow.

5.4.1 Ward organisation

The ward environment differs from classroom conditions as both students and mentors are exposed to real-life situations which include nurses, students, patients, and inter-professional interaction. Teaching and learning are therefore adjusted according to the various conditions and environments of the ward (Rajeshwaran 2016:472). In this study, the views of both students and nurses were sought regarding the overall ward organisation. The responses are presented in Tables 5.6 and 5.7.

The mean scores for students were in the range of (M=1.50 – 4.06) with a standard deviation greater than one (SD=1.204 – 1.699), while that for nurses was (M=3.00 – 4.27) and (SD=0.803 – 1.326), respectively. As noted, a majority of the responses has a standard deviation value greater than 1, which indicates that the data were not equal and not close to the mean. This implies that each value deviates or is different from the mean, which is suggestive of variation in responses from the respondents.

Table 5.6: Ward organisation (students n=115)

WARD ORGANISATION			
		STUDENTS (n=115)	
		Mean (M)	Std Deviation (SD)
1	Ward orientation of the student is the responsibility of the ward manager	4.06	1.372
2	The support of management is important to effective mentoring in the ward	3.76	1.204
3	The ward is viewed as a social entity, where students' professional growth is enhanced	3.34	1.213
4	The ward works in collaboration with all other health professionals	3.18	1.167
5	The ward provides a safe practice environment like use of protective equipment, infection control measures	2.56	1.500
6	The ward has standard operating procedures	2.55	1.440
7	The ward's nursing philosophy is clearly explained to students by the	2.18	1.699

WARD ORGANISATION			
		STUDENTS (n=115)	
		Mean (M)	Std Deviation (SD)
	ward manager		
8	Mentors show interest in patients' care in the ward	2.17	1.453
9	The ward manager ensures there is conducive learning environment	1.97	1.498
10	The staff shows interest in supervision of students	1.79	1.436
11	There is a shared understanding of mentoring in the ward	1.75	1.538
12	The ward is adequately resourced in terms of staff, equipment and supplies	1.50	1.360

Table 5.7: Ward organisation (nurses n=255)

WARD ORGANISATION			
		NURSES(n=255)	
		Mean (M)	Std Deviation (SD)
1	The support of management is important to effective mentoring in the ward	4.27	0.803
2	Ward orientation of the student is the responsibility of the ward manager	4.04	1.170
3	The ward's nursing philosophy is clearly explained to students by	3.66	1.234

WARD ORGANISATION			
		NURSES(n=255)	
		Mean (M)	Std Deviation (SD)
	the ward manager		
4	The ward is viewed as a social entity, where students' professional growth is enhanced	3.62	1.109
5	The ward manager ensures, there is conducive learning environment	3.59	1.146
6	The ward provides a safe practice environment like use of protective equipment, infection control measures	3.56	1.099
7	The ward works in collaboration with all other health professionals	3.54	1.056
8	Mentors show interest in patients' care in the ward	3.42	0.939
9	There is a shared understanding of mentoring in the ward	3.36	1.326
10	The ward has standard operating procedures	3.34	1.209
11	The staff shows interest in supervision of students	3.16	1.088
12	The ward is adequately resourced in terms of staff, equipment and supplies	3.00	1.319

The mean score for students was low for items 12 (M=1.50; SD= 1.360), 11 (M=1.75; SD=1.538), 10(M=1.79; SD=1.436) and 9 (M=1.97; SD=1.498). These scores also demonstrate that there are opposing views regarding the responses of the students to

that of nurses. This might be attributed to the context, since they were the first cohort of students following the DGN. The responses of nurses support the views of participants in Phase 1 to a great extent, in spite of the standard deviation value being greater than one.

A conducive CLE is mainly dependent on its organisational culture; how well the ward is organised and managed by the ward manager. The organisational culture is an important attribute of the CLE which determine the achievement of learning outcomes for a meaningful clinical experience (Flott & Linden 2016:501). Perhaps a well-organised ward is seen as one which is adequately resourced in terms of staff, equipment, and resources, but the need to have a broader view of a well-organised ward in the context of mentoring is vital. Papastavrou et al (2016:44) found that the leadership style of the ward manager and pedagogical atmosphere of the ward are influential factors for a conducive CLE. Similarly, participants in Phase 1 of the study also stressed the leadership and managerial skills of the ward manager as pre-requisites with regards to the good governance of the ward. However, consciousness among all nursing staff that the ward is a learning organisation which shapes professional growth, would likely contribute to maintaining a conducive CLE. Since learning is at the heart of the CLE, there must be a learning culture which fosters collaboration between mentors, staff and the training institution. Bvumbwe et al (2015:927) identified the support of academic staff and the ward managers as being key factors in ensuring a conducive CLE.

The views expressed by students on items 9, 10, 11 and 12 (Table 5.6) attest that managers put less effort in creating a conducive CLE and nurses show poor interest in supervising students. Similarly, there was no shared understanding of what mentoring was and the ward was not adequately resourced in terms of staff and equipment. This also supports the findings of Phase 1. Consequently, these factors would likely affect the quality of mentoring thereby impacting on the overall professional development of the students with regard to their fitness to practice. Addressing these shortcomings would likely contribute to improving ward organisation in the context of a conducive

CLE. A well-organised clinical setting would, therefore, respond in a more effective way to the overall needs of students' clinical placements. This also means that the ward organisation should provide a learning platform which can facilitate learners to attain their full potential and grow according to both Grow's (1991) and Benner's (1984) stages of professional development.

5.4.2 Communication and relationship

The frequent interaction of the mentor with students usually results in a relationship similar to the teacher and learner (Houghton 2016:42). This relationship binds both the learner and the mentor to work together in achieving common goals. In general, communication is considered a key element in all relationships. Within mentoring, both students and the mentors have a common interest in maintaining effective communication to sustain the relationship. The relationship within mentoring encompasses both the professional and interpersonal dimensions (Ali et al 2015:2; Lawal et al 2016:37).

Respondents' views were sought with regards to communication and relationships in response to 13 items, as shown in Tables 5.8 and 5.9.

Table 5.8: Communication and relationship (students n=115)

COMMUNICATION AND RELATIONSHIP			
		STUDENTS (n=115)	
		Mean (M)	Std Deviation (SD)
1	A mentor is a good professional role model	3.11	1.515
2	Mentors have leadership qualities	2.87	1.484
3	A mentor/ student relationship is trustful	2.77	1.463
4	Mentors provide guidance on professional issues	2.64	1.579

COMMUNICATION AND RELATIONSHIP			
		STUDENTS (n=115)	
		Mean (M)	Std Deviation (SD)
5	There are no barriers to information flow related to patients care	2.57	1.493
6	Mentors provide counselling for underachievers	2.40	1.685
7	Mentors provide emotional support where appropriate	2.35	1.539
8	Mentors consider the cultural learning aspect of the students	2.09	1.542
9	Mentors provide opportunities for discussion	1.68	1.454
10	Mentors give constructive feedback	1.57	1.482
11	Mentors show interest to support students in their clinical decisions	1.52	1.501
12	Mentors communicate regularly with the students	1.50	1.353
13	Mentors are accessible and available when required	1.41	1.407

Table 5.9: Communication and relationship (nurses n=255)

COMMUNICATION AND RELATIONSHIP			
		NURSES(n=255)	
		Mean (M)	Std Deviation (SD)
1	A mentor is a good professional role model	3.75	1.041
2	A mentor/ student relationship is trustful	3.68	0.925

COMMUNICATION AND RELATIONSHIP			
		NURSES(n=255)	
		Mean (M)	Std Deviation (SD)
3	Mentors have leadership qualities	3.62	0.918
4	There are no barriers to information flow related to patients care	3.59	0.846
5	Mentors provide guidance on professional issues	3.51	0.967
6	Mentors provide emotional support where appropriate	3.40	0.971
7	Mentors provide counselling for underachievers	3.35	1.147
8	Mentors consider the cultural learning aspect of the students	3.30	0.900
9	Mentors provide opportunities for discussion	3.16	1.197
10	Mentors show interest to support students in their clinical decisions	3.16	1.066
11	Mentors give constructive feedback	3.02	1.194
12	Mentors communicate regularly with the students	2.82	1.234
13	Mentors are accessible and available when required	2.73	1.271

The lowest mean score and standard deviation value for students were (M=1.41; SD=1.353), and that for nurses (M=2.73; SD=0.846). The highest mean score and standard deviation value for students were (M=3.11; SD=1.579) and that for nurses (M=3.75; SD=1.271). All the mean scores values for students were below 3, while all the standard deviation values were greater than 1. This indicates that the scores were not homogeneous as they were not clustered around the mean. It also indicates that the

responses from students varied. On the other hand, the majority of the responses from nurses have a mean value score greater than 3 and almost half of the responses have a standard deviation value of less than 1. This indicates there was a convergence of views among nurses with regards to items 2, 3, 4, 5, 6 and 8. The last five responses for students had a lower mean score ranging from (M=1.41 – 1.68). This also illustrates that the students' views were not the same compared to nurses', as shown in Table 5.9. Although there are differences in the scores for other items, it is apparent that both nurses and students shared common views to some extent.

Communication within the mentoring process helps in establishing connectedness between the mentor and students, which eventually instils confidence among students and motivates them to optimise their performance (Eller et al 2014:818). However, it could also be argued that communication could be a barrier to mentoring, especially if the mentor has poor listening skills. The quality of the mentoring process and the relationship between the mentor and the student relies on the way interactions take place and the dynamics within the CLE (Matin 2017:2). In short, communication should be seamless among all nurses, doctors and others who have an interest in supporting students' learning in clinical settings.

The responses of students on items 9, 10, 11, 12 and 13 with regards to accessibility, communication, feedback, discussion and willingness of the mentors to support students, also reflect what was highlighted by nurses in Phase 1 of the study. This confirms that the mentors were mostly unavailable to respond to students' needs consistently. This is supported by respondents' claims that students were often left on their own as shown in Table 4.2 under the category on students' issues. It would, therefore, seem this forms part of the challenges which students have to face during their clinical placement.

Indeed, the five items appear to be important attributes that could contribute to bringing togetherness among mentors and students for positive outcomes. Eller et al (2014:819) also found that open and supportive communication should include mutual respect and trust, exchange of knowledge and a caring personal relationship. The authors add that

these are a relational obligation which mentors have to honour towards students. Effective communication will, therefore, help the students to get things done and express their concerns while reinforcing the relationship. This captures the essence of communication regarding the relationship between the mentor and the student. Arguably, the mentor and student relationship could be enriched and reinforced if there is a constant flow of information within the mentoring process.

However, while emphasis should be placed on communication and relationships, mentors should also ensure that learning has taken place. Cunningham et al (2015:257) argue that mentors should be role models for their students and positive outcomes in clinical education is only possible when there are joint efforts between the mentor, student and the training institution. Students also prefer the sharing of resources, information and the professional roles of the mentor in problem solving (Hudson 2016:30), while Dimitriadou et al (2016:236) claim that the supervisory relationship of the mentor and individualised meetings are the most influential factors which students value. In addition to relationships, communication, time and available resources are critical to the mentoring process (Setati & Nkozi 2017:31). It thus seems that good communication and the sustainable relationship would promote good practice-based learning and teaching. Nonetheless, the traditional dyadic form of mentoring might not equip mentors with the wide range of skills to fully assume their roles compared to a stronger communication network which could provide robust support to mentoring (MacLaren 2018:66). This means the support provided to students during their clinical placements should not be the sole responsibility of the mentor. Instead, they should benefit from extended support from all nurses and other paramedical staff within the CLE who can directly or indirectly enhance their learning experience.

5.4.3 Mentoring

The role of the mentor has been recognised to be a challenging one as supporting students in clinical settings can be difficult (Brand 2016:3). Tables 5.10 and 5.11outline the responsibilities and tasks which mentors are supposed to perform.

Table5.10: Mentoring (students n=115)

MENTORING			
		STUDENTS (n=115)	
		Mean	Std Deviation
1	Mentors must clearly communicate responsibilities to students	3.38	1.496
2	Mentors encourage repeated practice of procedures by students under minimal supervision	2.80	1.464
3	Mentors work in collaboration with the clinical team	2.63	1.459
4	Clinical assessments of students are based on learning outcomes.	2.58	1.463
5	At the end of placement, mentors ensure students can perform effectively and are proactive	2.57	1.409
6	Mentors allow students to practice through simulations	2.54	1.326
7	All practical and learning activities of the students are recorded and documented	2.53	1.703
8	Mentors encourage students to practice under supervision	2.52	1.347
9	Mentors are committed to students' personal growth	2.41	1.589
10	Mentors always create a good learning environment	2.37	1.552

11	Mentors ensure that students acquire the necessary skills and competencies for their fitness to practice	2.31	1.441
12	Mentors are supported by highly skilled staff in speciality areas where there is high-tech medicine	2.22	1.669
13	Mentors help students to reduce the theory-practice gap	2.17	1.506
14	Mentors plan their work according to the learning outcomes and needs of the students	2.12	1.628
15	Mentors are allowed special time to mentor students	2.08	1.590
16	Mentors encourage students to engage in critical reflection	2.08	1.712
17	Mentors assist the students to evaluate their own learning experience	2.07	1.615
18	Mentors conduct both practical and theoretical assessment during practice placement of students	2.03	1.457
19	Mentors always promote evidence-based practice	2.00	1.493
20	Mentors respect student's level and styles of learning	1.98	1.595
21	Mentors encourage the optimal use of technology to facilitate learning	1.97	1.649
22	Mentors allow students to practice independently through reflection once they are confident	1.77	1.590

Table 5.11: Mentoring (nurses=255)

MENTORING			
		NURSES(n=255)	
		Mean	Std Deviation
1	Mentors must clearly communicate responsibilities to students	3.55	0.946
2	Mentors work in collaboration with the clinical team	3.54	1.041
3	Mentors always create a good learning environment	3.52	0.895
4	Mentors respect student's level and styles of learning	3.48	0.979
5	Mentors encourage students to practice under supervision	3.47	1.057
6	Mentors encourage the optimal use of technology to facilitate learning	3.44	1.165
7	At the end of placement, mentors ensure students can perform effectively and are proactive	3.43	0.957
8	Mentors encourage repeated practice of procedures by students under minimal supervision	3.40	0.979
9	Mentors ensure that students acquire the necessary skills and competencies for their fitness to practice	3.37	1.210
10	Mentors are supported by highly skilled staff in speciality areas where there is high-tech medicine	3.34	1.110
11	All practical and learning activities of the students are recorded and documented.	3.22	1.266

12	Mentors allow students to practice independently through reflection once they are confident	3.21	0.977
13	Clinical assessments of students are based on learning outcomes.	3.15	1.359
14	Mentors assist the students to evaluate their own learning experience	3.11	1.199
15	Mentors conduct both practical and theoretical assessment during practice placement of students	3.09	1.468
16	Mentors are committed to students' personal growth	3.05	0.993
17	Mentors encourage students to engage in critical reflection	3.04	1.374
18	Mentors plan their work according to the learning outcomes and needs of the students	3.00	1.552
19	Mentors help students to reduce the theory-practice gap	2.98	1.290
20	Mentors always promote evidence-based practice	2.97	1.276
21	Mentors allow students to practice through simulations	2.94	1.070
22	Mentors are allowed special time to mentor students	2.47	1.441

The responses are from students' and nurses' perspectives, respectively. The 22 items are ranked according to the mean scores of the responses from the respondents.

The mean scores value of nearly all responses for students were below 3, with a smallest mean value of (M=1.77 – 2.80) with the exception for item 1 which was

(M=3.38). The standard deviation value of all the items for the students was greater than 1, ranging from (SD=1.326 – 1.703). The mean scores below 3 and the standard value greater than 1 indicate that the data are spread, thus implying that students' responses varied. Similarly, the value of the mean scores of nearly all responses for nurses was greater than 3, ranging from (M=3.00 – 3.54), with the exception of items 19, 20, 21 and 22 which were below 3.00. Of the 22 items, more than half of the responses for nurses have a standard value greater than1, in the range of (SD=1.070 – 1.468) which shows that the data are not close to the mean. This also denotes that the responses among nurses are not alike. However, items 1, 3, 4, 7, 8, 12 and 16 have a standard value of less than 1, ranging from (SD=0.895 – 0.993), which implies that the scores were homogeneous as it was closer to the mean. This suggests that the responses were more or less consistent with regards to those items.

As noted in Table 5.8 and according to the findings, the views on the majority of the responses of students do not reflect the views of nurses. Nonetheless, the responses are aligned with the themes and categories of Phase 1 of the study "*A variety of activities/roles are described in everyday clinical practice*" and "*Aspects of mentoring found present"* (Table 4.2). The nurses' responses elicited from the interviews of Phase 1 of the study show they nearly share the same views as the students. Despite the range of tasks and responsibilities executed by the mentors, it is paramount that they develop diverse competence in certain domains with regards to mentoring. For instance, other than teaching and assessment, reflection during mentoring and identifying students' learning needs are also desired competencies which mentors should master (Tuomikoski, Ruotsalainen, Mikkonen, Miettunen & Kaariainen 2018:78).

Of the 22 items listed in Table 5.10, students considered item 1 (*mentors must communicate responsibilities to students*) to be most important, while item 22 (*mentors allow students to practice independently through reflection once they are confident*) was seen to be least important. Likewise, Table 5.11 confirms that nurses also considered item 1 to be most important, but item 22 (*mentors are allowed special time to mentor students*) was least important and not similar to students' views. Nonetheless, this

response from nurses is in contradiction from what nurses considered important in Phase 1 of the study *"mentors should be allocated enough time to support students"*. In contrast, a student-centred approach to mentoring and the support for their learning process were rated lowest in the study of Tuomikoski et al (2018:78).

It is also to be noted that the rest of the items are important as well since they overlap and are interrelated. For instance, items 3, 7, 8, 10, 17, 19 and 22 of the questionnaires are deemed to be important to mentoring. With regards to these items, students' responses were more dispersed and varied as compared to nurses' responses. Item 14 relates to the learning outcomes and needs of students, while item 15 refers to the time allocated by mentors to students. It would seem crucial for the mentor to reconcile these two factors as this would facilitate the mentor to manage the students' clinical training. For instance, this would ensure that learning outcomes and the duration of clinical placement are met. However, meeting the learning needs of students in the clinical settings could be challenging, and one way of addressing this is to introduce a mentoring programme for students during their training. Tengah (2016:37) stressed the benefits of a mentoring programme for pre-registration student nurses. The author noted that students valued the sharing of experience and development of knowledge, the opportunity to learn new things, the improvement in acquiring skills, and being assertive and independent. However, Cunningham et al (2015:257) found that system structures and people in the CLE contribute to a great extent in supporting the learning needs, and preparing the learning outcomes to overcome the theory-practice gap. For this purpose, both students and mentors should share responsibilities as pointed out by participants in Phase1 of the study, under the theme "*pre-requisites needed for the mentoring process*" (Table 4.2).

The training and empowerment of mentors to stay current are vital to mentoring. This was also highlighted by participants in Phase 1 of the study. Nonetheless, the implementation of a training programme for mentorship can be challenging owing to certain factors, such as lack of organisational support, the absence of a learning culture and unavailability of trainers, as reported by Nowell, Benzies, White and Rosneau

(2017:1). The mentor has broad responsibilities and it could be argued that addressing the theory-practice gap is considered a key objective of mentoring, particularly in the context of evidence-based care. However, the integration of evidence-based practice can be problematic due to a lack of knowledge, skills and updated evidence sources (Farokhzadian, Khajouei & Ahmadian 2015:1107). Moreover, the gap that exists between what is taught at school and what students experience in the wards has been well documented (Saifan et al 2015:20; Cunningham et al 2015:257). Participants in Phase 1 of the study felt that they were not competent enough to address the theory-practice gap and believed that the support of the educators is necessary. In their study, Mwale and Kalawa (2016:1) also identified that a knowledge gap between qualified nurses and tutors was a factor that can affect mentoring. This suggests that the bridging of the theory-practice gap in clinical placements could be best addressed through collaboration between the mentor and the educators. Furthermore, the bridging of the theory-practice gap can also be achieved through students' peer mentoring, when they are equipped with clinical skills, psychomotor skills and academic skills (Rohatinsky, Harding & Carrier 2017:61).

The overall responses on mentoring from both students and nurses from Tables 5.10 and 5.11 illustrate that the views expressed differ. Sample t-test was used to test differences. The differences were noted with regards to responses relating to ward organisation, communication/relationship and mentoring, as shown in Tables 5.10 and 5.11. The t-statistics values and mean values from both tables are indicative of the differences. The findings also support the second objective and the research question of the study, namely whether mentoring is differently perceived by students and nurses in the local context.

5.4.4 Barriers to effective mentoring

There are many constraints and challenges which both students and nurses face in the clinical settings. System factors related to ward organisation and resources within the health system have been identified as barriers that hinder effective mentoring (Anarado

et al 2016:1-20). Tables 5.12 and 5.13 present some of the factors which likely impact on mentoring in the CLE from both students' and nurses' perspectives. These factors have been ranked according to the mean scores.

The mean scores of all responses for students were greater than 3 in the range of (M=3.55 – 4.26), while that for nurses was (M=3.21 – 3.98). The standard deviation for all responses was greater than 1 for both students and nurses in the range of (SD=1.012 – 1.588) and (SD=0.822 – 1.362), respectively. This indicates that the responses were not concentrated around the mean and the data set lies farther away from it. This also implies that there were variations in individual responses. Some responses for nurses regarding items 1, 2, 3, 5, 6, 7, 9 and 10 had low standard deviations, less than 1, indicating that the responses were concentrated around the mean that is there was some kind of uniformity in their responses. The pattern of the scores of both students and the nurses denotes there is a difference with regards to both responses.

Table 5.12: Barriers to effective mentoring (students n=115)

BARRIERS TO EFFECTIVE MENTORING			
		STUDENTS(n=115)	
		Mean	Std Deviation
1	Staff shortage	4.26	1.132
2	Ineffective planning regarding practice placement of students	4.15	1.086
3	Increased workload	4.10	1.304
4	Lack of knowledge, skills and competencies of mentor	4.02	1.147
5	Poor management support to learning	3.97	1.143
6	Lack of practice supervision	3.97	1.280
7	Absence of follow-up on students due to shift system	3.97	1.166
8	Unrecognised role of mentors	3.97	1.147

BARRIERS TO EFFECTIVE MENTORING			
		STUDENTS(n=115)	
		Mean	Std Deviation
9	Inadequate learning resources	3.96	1.012
10	Lack of collaboration between school and practice placement	3.90	1.273
11	Negative attitude of mentors	3.75	1.220
12	Poor professional relationship	3.73	1.187
13	Dual role as a carer and mentor	3.72	1.301
14	Mentoring too many students at a time	3.71	1.588
15	Autocratic and inflexible approach of mentors	3.55	1.320

Table 5.13: Barriers to effective mentoring (nurses n=255)

BARRIERS TO EFFECTIVE MENTORING			
		NURSES(225)	
		Mean	Std Deviation
1	Staff shortage	3.98	0.980
2	Inadequate learning resources	3.92	0.857
3	Lack of collaboration between school and practice placement	3.89	0.870
4	Increased workload	3.86	1.061
5	Lack of practice supervision	3.85	0.822
6	Ineffective planning regarding practice placement of students	3.84	0.970
7	Mentoring too many students at a time	3.83	0.944
8	Poor management support to learning	3.82	1.070
9	Lack of Knowledge, skills and competencies of mentor	3.76	0.928
10	Absence of follow-up on students due to	3.74	0.876

BARRIERS TO EFFECTIVE MENTORING			
		NURSES(225)	
		Mean	Std Deviation
	shift system		
11	Dual role as a career and mentor	3.68	1.362
12	Unrecognised role of mentors	3.63	1.153
13	Autocratic and inflexible approach of mentors	3.59	1.003
14	Poor professional relationship	3.51	1.093
15	Negative attitude of mentors	3.21	1.256

Tables 5.12 and 5.13 show the responses with regards to items 1-15. These are commonly viewed as common problems which both mentors and students experience daily in the CLE. These barriers tend to contribute to an unsupportive learning environment if proper attention is not given and addressed. The findings corroborate the views from Phase 1 of the study. This was discussed under the themes *"mentoring was in the form of clinical accompaniment"* and "*pre-requisites needed for the mentoring process".* The barriers listed in the tables are associated with organisational, pedagogical and relational aspects of mentoring. In contrast, Lee et al (2018:103) found that socio-cultural, environmental and physical factors are also barriers to mentoring.

The organisational aspects of the CLE relate to the overall management of the ward in terms of staffing, equipment, and other resources as have been highlighted in studies (Baraz et al 2015:57; Dlama et al 2016:5). Broadly speaking, the pedagogical aspects with regards to mentoring refer to learning resources, the teaching skills of the mentor, learning styles, assessment, and the integration of theory into practice by the students. In other words, it tends to focus on how effective teaching and learning takes place within the CLE.

Although all the items illustrated in Tables 5.12 and 5.13 are potential barriers, item 1, that is "*staff shortage*", was found to be the most important barrier by both students and

nurses. This is consistent with the findings of other studies as well (Oluchina & Gitonga 2016:29; Nowell et al 2017:1). Staff shortage can affect students' learning support; in fact, nurses have to give priority to patients' care which eventually leaves them little time to dedicate to students. The least important responses (item 15) reported by nurses and students were not alike. This relates to the "*negative attitude of mentors*" for nurses and "*autocratic and inflexible approach of mentors*" for students. Arguably, these two barriers do not promote a positive relationship between the mentor and student. However, the caring attitude of mentors is a key element in the mentoring process (Setati & Nkosi 2017:131). The discussion that follows will focus on the first five items from Table 5.10. These barriers seem to have a great impact on mentoring in the local context.

For instance, addressing item 2 "*ineffective planning regarding practice placement of students*" in a holistic way can likely results in effective mentoring. Participants in Phase 1 stated that students' placement requires "*prior planning regarding students' placement and nurses involved in mentoring*". Respondents in Phase 2 of the study were also unanimous in recognising that the mentoring system was informal. This confirms that there is ineffective planning regarding the mentoring system and the current practice is not efficient for its purpose. In a systematic review, Muleya et al (2015:571) identified the need for feedback, hands-on practice, continuity in a mentoring and mentor-mentee relationship are important areas that require attention when planning students' placement. The authors also noted that gaps within a mentoring programme could negatively impact on students' clinical learning. This means mentors should undergo relevant training which is in line with professional standards. Hence, it seems effective planning requires commitment and responsibilities from mentors, nurses and the students. According to Leary, Schainker, Anna and Leyenaar (2016:219), a mentor has an interest to stay focus in a comprehensive way, sets clear expectations and acknowledges his limitations. The authors also pointed out that the student has to be proactive, well prepared and inquisitive.

Staff shortage and workload are two factors that could have an overall impact on mentoring, particularly if the mentor is also involved in the caring of patients. Similar findings were reported in a study by Oluchina and Gitonga (2016:29) in Kenya, as these two factors were rated as being highest barriers to mentoring, while Mwale and Kalawa (2016:2) found that lack of adequate resources and workload within the CLE can affect students' acquisition of skills and knowledge. This was also observed by one participant during the first phase of the study, who mentioned that "*At time workload at ward level does not allow me to spend enough time with the students".*

Management at all levels has an important role to play with regards to mentoring. A well-managed ward also implies that the manager facilitates the provision of all necessary resources in terms of staffing and equipment to render the clinical settings into a conducive CLE. A participant in Phase 1 of the study stressed that "*it is important that there is a good relationship between the management, the mentor and the students and clinical setting must be well equipped in terms of equipment and staffing".* Dlama et al (2015:57) also identified in their study that a shortage of staff and equipment and poor interpersonal relationships with the mentor are barriers to mentoring. Inconsistent support from management can, therefore, impact negatively on mentoring if the requirements for a conducive CLE are not met.

Both students and nurses in this phase of the study recognised that lack of knowledge, skills, and competencies of the mentor are barriers to effective mentoring. Participants in the qualitative phase of the study also acknowledged that mentors should have certain skills, as mentioned in Table 4.2. In their study, Mubeezi and Gidman (2017:101) reported that mentors identified gaps in their knowledge and skills despite being aware of what was expected of them in terms of good qualities of a mentor. Similarly, Bvumbwe et al (2015:928) found that poor clinical teaching environments and poor competence of nurses impede on the learning process of students.

While all the factors mentioned in Tables 5.12 and 5.13 are potential barriers to effective mentoring, the practice of mentoring within nursing varies across settings, and the lack

of a standard approach renders it problematic (Matin 2017:1). Despite existing barriers, Harding and Mawson (2017:1) reported that students positively viewed their professional growth as they felt nurtured and experienced a deeper and richer learning environment. Indeed, all the barriers mentioned in the tables cut across the CLE, as experienced by the students and the mentors. This was confirmed in a recent systematic review by Drateru (2019:4), and included lack of staff and equipment, poor supervision and interpersonal relationship, mismatch of students' allocation, widening of theory-practice gap and lack of time.

5.5 RESULTS COMPARISON

A one-sample t-test was run to determine differences in responses with regards to students and nurses as illustrated in Table 5.14. The test value score was set at 3.0 for both samples. For students, the mean ward orientation score (2.57 ±0.72) was lesser than 3.0 with negative differences of -0.43(95%; CI, -0.56 to -0.29), t (254) = -6.407, p=0.000. The negative values draw from the sample size and the test value. The mean barriers score (3.92 ± 0.88) was greater than 3.0, a statistically significant difference of 0.92 (95%CI, 0.75 to1.08), t (115) =11.193, p =0.000. The mean ward orientation score (6.16 ± 0.62) was higher than 3.0, a statistically significant difference of 3.1 (95%CI, 3.0 to 3.2), t (254) = 17.375, p = 0.000. Mean barriers score (3.74 ±0.68) was higher than score 3.0 a statistically significant difference of 0.65 (95%CI, 0.65 to 0.82), t (254) = 17.375, p = 0.000. It is evident from the table that there were differences in the responses of nurses and students, particularly with regards to ward orientation which is central to the CLE.

Table 5.14: Sample T-test

	TEST VALUE = 3.0							
STUDENTS	**M**	**SD**	**t**	**df**	**Single (2 tailed)**	**Mean difference**	**95% Confidence interval of the difference**	
							Lower	**Upper**
Ward organisation	2.57	0.724	-6.407	114	0.000	-0.43261	-0.5664	-0.2988
Barriers	3.92	0.883	11.193	114	0.000	0.92120	0.7582	1.0842
NURSES								
Ward organisation	6.16	0.620	81.583	254	0.000	3.16536	3.089	3.2441
Barriers	3.74	0.680	17.375	254	0.000	0.74044	0.656	0.8244

5.6 SUMMARY

This chapter has examined the views of both nurses and students in terms of mentoring. The qualitative findings of Phase 1 of the study were used to inform this phase of the study. Emphasis was placed on the background information of the participants, the current practice of mentoring, and the CLE. The results discussed in this chapter put the qualitative findings in perspective, and the differences noted in the responses also confirm that mentoring was perceived differently by both students and nurses in the local context. The findings also attest that learning support for students is more orientated towards clinical accompaniment. To some extent, the overall findings also reflect what has been reported in other studies. The next chapter will build on the findings of the mixed method to develop a clinical mentoring framework for student nurses in Mauritius.

CHAPTER 6
A CLINICAL MENTORING FRAMEWORK FOR STUDENT NURSES IN MAURITIUS

6.1 INTRODUCTION

The findings from the qualitative and quantitative phases of previous chapters (Chapters 4 and 5) outlined how mentoring was perceived by both the qualified nurses and third-year students who were on clinical placements. This chapter examines the relevant concepts from the findings to integrate the results of the study and develop a framework of mentoring for student nurses, using the survey list as suggested by Dickoff et al (1968:423).This framework captures major concepts related to mentoring to provide a structure which also demonstrates how the mentoring process is a multi-dimensional phenomenon. It considers the factors from both the mentor's and the student's perspective for effective clinical mentoring.

6.2 CONCEPTUAL FRAMEWORK

A framework refers to a structure that provides support around which something can be built (Cambridge Dictionary 2018). The term 'conceptual framework' is often used in nursing literature. A conceptual framework is the basic support of a structure which can be further expanded into something useful to give direction (Nghipondoka-Lukolo & Charles 2016:172). Likewise, a conceptual framework is devised by theorists to respond to situations to attain the desired results (Amukugo, Jooste & Van Dyk 2015:123). Imenda (2014:189) affirms that a conceptual framework is usually the outcome of a study which attempts to bind together related concepts to get a broader understanding of the phenomenon of interest. The author further argues that a conceptual framework tends to bring together all concepts to understand possible relationships through an inductive process. In other words, it serves as a guide for devising or building a structure.

In this study, the conceptual framework was structured according to the survey list as suggested by Dickoff et al (1968:423). This enabled the identification and categorisation of major concepts from the findings of the study and relevant empirical studies towards the logical development of the conceptual framework.

6.2.1 Development of the framework

In this study, the development of the framework draws from the survey list as described by Dickoff et al (1968). According to this survey list, it is important to identify, clarify and explain concepts to achieve the intended outcomes. Dickoff et al (1968:115) also state that theory is generated in practice and nursing theory, nursing research, and nursing practice, which are mutually interdependent and interrelated. The survey list proposed by Dickoff et al (1968:422) focuses on six important components of activity. This consists of the agent, the recipient, the context, the dynamics, the procedure and the terminus or outcome, as shown in Table 6.1.

Table 6.1: Dickoff et al (1968) survey list

1	**AGENT**	*Who or what performs the activity?*
2	**RECIPIENT**	*Who or what is the recipient of the activity?*
3	**CONTEXT**	*In what context is the activity performed?*
4	**DYNAMICS**	*What is the energy source for the activity?*
5	**PROCEDURE**	*What is the guiding procedure, technique or protocol of the activity?*
6	**TERMINUS**	*What is the endpoint of the activity?*

In applying these components to this study, the following applies:

- The agents refer to clinical mentors.
- The recipients include the students with their willingness to shape their professional growth and move along the continuum of novice to expert for their fitness to practice.

- The context refers to the CLE with its network of forces within which clinical mentoring takes place.
- The dynamics for this framework are the motivational factor that drives the activity, which is a passion centred philosophy.
- The procedure involves the mentoring process.
- The terminus refers to the outcome of the process, namely competent students who are fit for practice.

6.3 AGENT

According to Dickoff et al (1968:421), an agent refers to the person who performs the activity. In this study, the agents are qualified experienced nurses who are involved in clinically mentoring students in the wards. These nurses will be the driving force who can promote the practice of mentoring through the use of the clinical mentoring framework. Ideally, the agents should possess certain qualities to support the students' learning effectively. Participants in the study acknowledged that trained and qualified mentors should undertake the mentoring of students. Since clinical mentoring is concerned with the training and professional development of student nurses, the clinical mentor needs requisite knowledge, skills, and attitudes as illustrated in Figure 6.1. Additionally, the RCN (2017) requires mentors to achieve the level of knowledge, skills, and competence to meet defined outcomes for effective mentoring. This also suggests that clinical mentoring cannot informally take place.

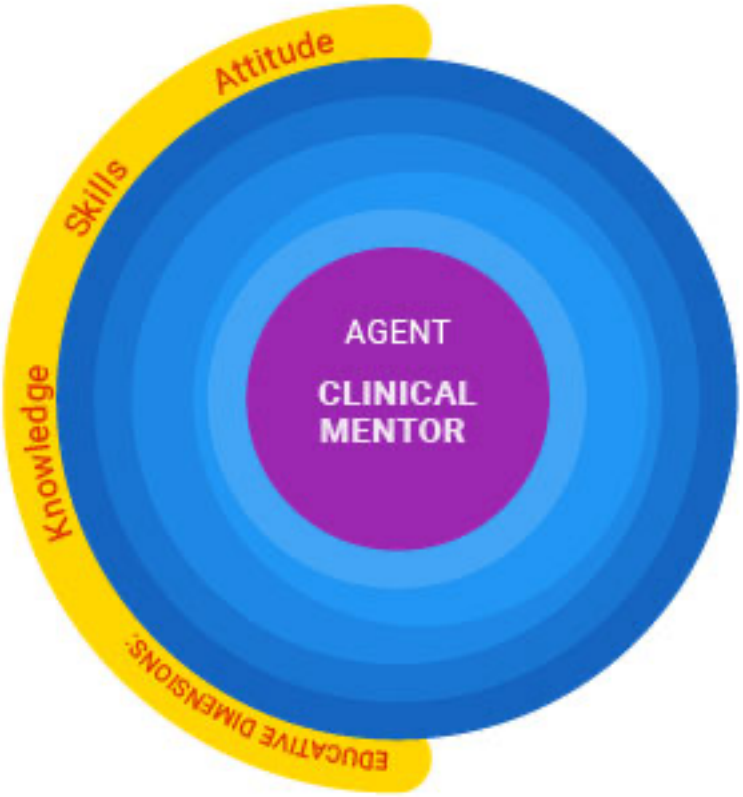

Figure 6.1: The agent

6.3.1 Knowledge acumen

The clinical mentor is commonly viewed as someone who provides learning support to students in practice placement (De Abreu & Interpeller 2015:45). Hence, it would seem that the key activity of the clinical mentor is directly associated with learning support which forms part of nursing education. Clinical mentoring remains the primary component of nursing education, which broadly encompasses teaching, learning, and assessment (Jamshidi et al 2016:155; RCN 2017). In addition, the clinical and mentoring knowledge of the mentor also contributes to the core educative dimension of clinical mentoring.

6.3.1.1 Teaching, learning, and assessment

In general teaching, learning and assessing have been recognised as key skills which someone should have when involved in training (Matin 2017:3; RCN 2017). Participants in this study revealed that these competencies go hand in hand, as it allows the mentor to achieve the anticipated learning outcomes. The learning process thus involves teaching, learning and assessing since learning does not take place with either teaching or assessing alone.

Within the clinical settings, clinical mentors provide learning support to students through teaching and assessing. This enables the students to integrate theory into practice and prepares them for their fitness to practice. The learning process, therefore, has a direct impact on the professional development of students, and ensuring its effectiveness can be challenging. Prior to any teaching or learning taking place, the clinical mentor needs to be aware of the required learning outcomes to align all further actions. Clarifying the learning outcomes with the students gives them direction about what they are supposed to achieve, and these must be communicated to them in writing (Mahajan & Sherjitsingh 2017:66). This implies that both mentors and students are committed to attaining the desired results of the clinical training. For instance, one learning outcome for a student posted in a surgical ward could be “the student should be able to set a trolley for dressing using the aseptic technique”. Thus, the learning outcomes serve as a guide to mentors regarding the theoretical and clinical aspects which the students should know.

Likewise, meeting the learning outcomes of clinical practice is dependent on the effectiveness of the learning support in the CLE (Phuma-Ngaiyaye, Bvumbwe & Chipeta 2017:168). The clinical mentors or educators should ensure that the learning needs of students are met in the clinical placements. Since students are adult learners, it is incumbent on the mentors what teaching or learning strategy they will use regarding clinically mentoring students. There are many approaches to addressing the learning needs of the students in a clinical setting, but all health professionals should adopt clear

reasoning for educational activities and make effective use of learning theories (Aliakbhari et al 2015:2).

6.3.1.2 Grow's staged self-directed model

This theory is based on the assumption that the goal of education is to produce self-directed lifelong learners which promote orientating oneself to education at all levels (Grow 1991:127). Furthermore, the model is inspired by leadership styles which promote critical thinking, require less interaction and favour learning that is student-led (Grow 1991:134). The author argues that teaching is situational and depends on the 'readiness' of the learner which is a combination of ability and motivation. Thus, the application of this model to clinical mentoring is considered relevant as well. This model is aligned with Benner's Novice to Expert Theory as the mentor is seen as someone who has authority, starts by coaching students (novice), and is motivated to guide through his experience (advanced beginner). He/she then acts as a facilitator (competent) and becomes a consultant (expert). Arguably, Grow's (1991) Self-directed Model tends to match Benner's Novice to Expert Framework and has the merit of providing a broader perspective from both the students and the clinical mentors.

This suggests that the students should apply effort and take control of their learning. On the other hand, the mentor should ensure that the students are compliant with their responsibilities. Instead of constantly assisting the students, the mentor should motivate and orient them towards self-directed learning where the students are committed to their professional growth. Grow (1991:125) contends that self-directed learning involves the empowerment of the students towards greater autonomy along with the teacher and student control. This model, therefore, seeks to initiate the learner at the very start to be self-dependent, instead of relying on the teacher to become dependent at a later stage. Similarly, with regards to clinical mentoring, the students need to be exposed at the very start to the concept of self-directed learning. Grow's model posits that learners undergo four stages, and these are summarised in Table 6.2.

Table 6.2: The Stage Self-directed Learning Model adapted from Grow (1991)

STAGE	STUDENTS	TEACHER	EXAMPLES
1	Dependent	Authority (Coach)	Coaching with immediate feedback, drill, informational lecture, overcoming deficiencies and resistance.
2	Interested	Motivator (Guide)	Inspiring lecture plus guided discussion, goal-setting and learning strategies.
3	Involved	Facilitator	Discussion facilitated by teacher who participates as an equal, seminar, group projects.
4	Self-Directed	Consultant (Delegator)	Internship, dissertation, individual work or self-directed study-group.

The four stages are interrelated and overlap each other. These stages are also in line with what participants in Phase 1 of the study stated; that is, they coach, motivate and facilitate students' learning. Likewise, clinical mentors must at the very outset mobilise all their efforts to engage the students, as advocated by Grow's model. This includes simulation exercises, discussion, feedback and identifying and addressing weaknesses. It also indicates that the same principles could be applied to clinical mentoring. The clinical mentor should, therefore, demonstrate the qualities of the teacher, namely having authority and being motivational in addition to being a facilitator and consultant.

6.3.1.3 Mentor as an authority

In general, learning in Stage 1 tends to be teacher-centred. There is also a perception among the students that they should rely on the teacher as the latter is in a better position to respond to their learning needs. In contrast, the students have a certain degree of control, which Grow (1991:128) referred to as learners of low self-direction. One approach to assisting dependent learners is through coaching and the mentor's

authority is crucial, as shown in Table 6.2. Within clinical settings, coaching is unique and unconventional in itself as it empowers nurses or students to be more responsible and accountable to adjust to changes that can impact on their personal and professional life (Walker-Reed 2016:42). It is also considered an approach to promote mutual learning, goal achievement and professional development (Gurbutt & Gurbutt 2016:89). Hence, coaching could be seen as a skill in clinical mentoring.

6.3.1.4 Mentor as a motivator

The mentor's role in the second stage involves motivation on his part to guide the students, as these students are interested and show a willingness to practice instruction. They are referred to as learners of moderate self-direction (Grow 1991:130). The mentor should be able to bring enthusiasm and motivate the students to engage in learning activities. The mentor should, therefore, provide help and direction for the students to become more self-directed. For example, the mentor should promote good communication, help in setting goals, organise teaching sessions and use appropriate teaching strategies. The use of teaching strategies motivates students to engage in the learning process while it also assists the mentor to deliver high-quality education (Xu 2016:56). Likewise, coaching integrates learning and development through adult learning strategies where students are given full opportunities to practice on their own under the guidance and supervision of the mentor (Faithfull-Byrne, Thompson, Schafer, Elks, Jaspers, Welch et al 2015:403).

6.3.1.5 Mentor as a facilitator

According to the third stage of Grow's model, as the students progress, they gain skills and knowledge and the mentor should act more as a facilitator to reinforce self-direction. This instils confidence in the students who feel they can undertake certain tasks; they are considered as learners of intermediate self-direction, as Grow (1991:133) puts it. Grow (1991:133) further claims that students develop critical thinking and take individual initiative where they feel they can help others, along with their

mentor. Thus, the mentor's role is to involve the students in the learning process and prepare them to be more independent. For instance, there is a sharing of views in decision making between the teacher and the student where the latter is given an increasing role. The RCN (2017) advocates that a mentor should act as a facilitator for the students regarding working with other health professionals, related learning issues, their performance, and experience. Similarly, De Abreu and Interpeller (2015:45) found that students prefer mentors who can facilitate a learning and mentoring relationship.

6.3.1.6 Mentor as a consultant

It is in Stage 4 of the model that the mentor's role is seen as a consultant. In fact, at this stage, students are considered as learners of high self-direction and can take responsibility and be independent (Grow 1991:134). Concerning clinical mentoring, the mentor's role is to provide expert advice to the students regarding their fitness to practice and their purpose (RCN 2017). The final aim of Stage 4, therefore, relates to the autonomy of the student and their empowerment which is monitored by the mentor as a consultant. As a consultant, the mentor should be an expert in his field of practice, along with having clinical knowledge, and the ability to respond to all the needs of the students in an effective manner. Hence, his key focus should be on teaching, learning, and assessing students in a comprehensive way during their placement.

However, one major challenge often faced by mentors is dealing with students who have not reached the expected proficiency level for fitness to practice. In response, Burgess and Mellis (2015:379) recommend that mentors, faculty members, and management should collaborate in assessing students who are low performers. Given that the learning process encompasses teaching and assessing, due consideration should be given to the training, education and ongoing support of mentors (Benette & McGowan 2015:454).

In addition to teaching and assessing, feedback remains an important tool that assists educators to provide and gather information to ensure that learning has taken place

(Hardevella, Aamli-Gaagnat, Saad, Rousalova & Sreter 2017:327). Ongoing feedback given constructively enhances reflective and experiential learning while it also instils confidence and contributes to students' satisfaction and expectation (Agudo 2016:51; Hardevalla et al 2017:332). However, too often students have complained of poor and inadequate feedback due to a lack of skills in giving and receiving feedback from the mentor (Burgess & Mellis 2015:381).

6.3.1.7 Clinical knowledge

As an agent, the mentor should demonstrate that he has the necessary knowledge and skills to prepare students for their professional roles (Setati & Nkosi 2017:130). This also suggests that the clinical mentors must ensure that students acquire the relevant skills and knowledge so that they can deliver care that is patient-centred. Furthermore, this allows the students to better understand patients' situation, their expectation, and needs. However, the clinical knowledge and skills of the clinical mentor coupled with his experiences also lead to 'clinician clinical expertise' which is an important component of evidence-based practice (Thompson 2016:1). This implies the use of acquired knowledge along with caring experiences in clinical decision making for best patient outcomes. Hence, the expert clinical mentor should inspire the students to grow and develop as knowledge and expertise are important requirements for transforming novice students into a future expert (Walker-Reed 2016:47).

6.3.1.8 Mentoring knowledge

There are several terms associated with mentoring, such as assessing, preceptoring, supervising and coaching, yet they have different meanings (Peak & Kelly 2016:19). This brings to light the lack of a universal understanding of the mentoring process with regards to nursing education (Matin 2017:1). It is therefore important that nurses and students know what mentoring entails, since it may pose as challenges or barriers to effective mentoring along with role conflict and ambiguity. Indeed, the mentoring process primarily involves a relationship between the students and the mentor, the

transfer of knowledge and skills through the integration of theory into practice, along with regular feedback (Matin 2017:3).

6.3.2 Skills required

In addition to being knowledgeable, nurses should also possess certain skills for the proper discharge of their duties. Similarly, clinical mentoring also requires certain skills since it involves the guiding, teaching and supervising of students in the CLE. In simple terms, skill refers to the ability to perform a task in the most efficient way, following acquired experience and training (Macmillan Dictionary 2018). William (2018:1) argues that mentors should develop a set of skills which would help in enhancing the performance of others. In this study, three essential skills emerged from the findings, namely the interpersonal, management and leadership skills.

6.3.2.1 Interpersonal skills

Interpersonal skills refer to a set of qualities, which the mentors have to develop to effectively respond to the learning needs of the students (De Abreu & Interpeller 2015:45). Mentoring is, in essence, a relational process (William 2018:2) and remains the single most crucial factor for effective clinical mentoring (Ali et al 2015:2; Lawal et al 2016:37). Although trust, respect, and confidence were aspects of mentoring noted by participants, the communication and relationship aspects were not consistently being practised (Chapter 6). The relationship between the mentor and student is vital in clinical mentoring.

Mentoring relationships have been described as a complex interactive process, which involves learning, interaction, development and adaptation (Goodare 2015:38). It has been identified as an influential factor for effective clinical mentoring (Manister & Frederickson 2016), while it also encompasses both professional and interpersonal relationships between the mentor and the mentees (Ali et al 2015:2; Lawal et al

2016:37). For this reason, it can also be argued that the mentoring relationship contributes largely to shaping the professional growth of the student.

Clinical mentoring requires the establishment of relationships as advocated by the NMC (2008). In a mentoring relationship, the element of belongingness is important and it should be felt and shared by both mentor and student to keep the mentoring process ongoing (Vinales 2015:534). Building a mentoring relationship requires effort, planning, collaboration and regular meetings (Houghton 2016:40).

Effective interpersonal relationships principally revolve around the way we stay connected with others and it is the outcome of good communication (Nangombe & Amukugo 2016:51). The agent/clinical mentor should adopt openness, be approachable and communicate expectations and respond to the recipient (Ndempavali & Amukugo 2016:105). This also includes mutual respect, communication through regular feedback, being approachable and adaptable, showing empathy, role modelling, listening and counselling (Vinales 2015:532). Maintaining good communication with key stakeholders at all levels is paramount. This includes the regulatory body, the training institution, and the hospital providing the placement.

6.3.2.2 Managerial and leadership skills

In this study, participants emphasised that mentors should be equipped with managerial and leadership skills. The successful outcome of any activity in an organisation is dependent on the agent who is managing and leading. Similarly, clinically mentoring students in CLE requires appropriate management by the clinical mentors to achieve the shared objectives set out by the mentors and students, the training institution and the hospital management. Participants in this study reported that many constraints impede on clinical mentoring, such as staff shortage, poor placement planning, lack of equipment and unsupportive management. These observations were in line with other studies (Anarado et al 2016:16; Baraz et al 2015:57; Dlama et al 2016:57). For this reason, the mentor must demonstrate managerial and leadership skills to better

manage the placement programme and lead the group of students in an effective way. To maintain standards in learning practice, the NMC (2008) advocate that mentors are required to have leadership competencies.

Expertise in leadership is also considered as an important dimension of competence (Ndempavali & Amukugo 2016:104). In fact, a combination of both skills along with knowledge, values, and technical abilities are key characteristics that determine the competence of the agent (Ndempavali & Amuguko 2016:104) and enables the agent to manage and lead more effectively. Leadership skills could help the mentors feel more confident in decision making and solving problems they encounter within the CLE. For instance, they could take initiative on their own instead of relying on the ward manager regarding lack of equipment. They could also negotiate directly at a higher level, such as the school or management as deemed appropriate. Thus, leadership is a core competency which a mentor must demonstrate (NMC 2008) to deal with, handle and resolve problems on their own. In other words, the managerial and leadership skills will better empower mentors in eliminating barriers for the improvement of clinical mentoring, while being more autonomous.

The mentor has to plan, coordinate and control a group of students who are posted in a different setting at a time, which is contrary to classroom settings. Moreover, he or she has to liaise and collaborate with other stakeholders. This might be more challenging when working in under-resourced settings. The agent should, therefore, ensure that the recipients are motivated, properly guided, encouraged, and their relevant skills have been reinforced to practice the activity by providing the material resources according to their needs (Dickoff et al 1968:425).

6.3.2.3 Mentoring skills

As a concept, mentoring is not limited to the mentioned skills only, as mentors need training to develop some specific skills as well. Some common specific mentoring skills include being observational and analytical, in addition to listening, reflecting and offering

feedback (William 2018:1). For instance, through active listening and feedback, the mentor can ask questions and share views. This provides a platform for the students to interact and feel a sense of belongingness. These specific skills are therefore paramount as they tend to contribute to enhancing the performance of students. However, knowledge, skills, and attitudes are commonly referred to as the cognitive, psychomotor and affective dimensions of teaching and learning (Warburton, Houghton & Barry 2016:41); that is, the ability to use reasoning, to perform an activity or procedure and to have values, beliefs and feelings. In a mentoring relationship, knowledge, skills and attitudes of both mentor and the students should go in a pair as the approach to nursing education has increasingly been shifting from the traditional teacher-led to a student-centred one (Warburton et al 2016:44).

6.3.2.4 Attitudes to be formed

The mentor's attitudes towards the students and the teaching strategies used with regards to clinical mentoring are critical determinants for the quality of clinical learning experiences of nursing students (Gangadharan et al 2016:651). The correct attitude involves being friendly, approachable and sociable (Nangombe & Amukugo 2016:104), which implies that the clinical mentor should have desirable behaviours to remain connected with the students. There are common factors that contribute to the image of a good mentor and a good student. Good clinical teachers should be effective role models and have the ability to understand individual differences and learning process of students (Goldie et al 2015:34). The mentor's attitude has an impact on the personal transformation of students and their empowerment (Al Qahtani 2015:150), which indirectly influences their behaviours and professional values (Norman 2015:33).

However, students' professional behaviour and values also have an impact on the mentor's attitude (Joubert & De Villiers 2015:1). For example, this might include a caring relationship, showing self-respect and being responsively reciprocating towards each other.

6.3.2.5 Self staged directed learning from a mentor's perspective

As discussed, the mentor's knowledge, skills and attitudes are central to the mentoring process. As agent, the mentor's main goals are to guide and supervise the students in their learning continuum from novice to expert to allow them to become independent. Grow's (1991) model requires the teacher (mentor) to coach, guide, facilitate and delegate. The purpose is to act as a consultant for the learner to become self-directed in his/her learning. In spite of this, there was a willingness to support students' learning among participants in this study, who acknowledged that the mentoring system was informal. Mgbekem, Ojong, Lukpata, Armon and Kalu (2016:250) argue that formal education is fundamental to the acquisition of clinical skills and knowledge. This also means that formal education requires compliance from learners as they have to progress from the novice stage to that of expert. However, being too dependent on others hinders growth in adult learning (Grow 1991:133). For this reason, the mentor needs to adopt a student-centred approach so that the learner can stay committed and show interest in his professional growth.

In this study, the participants reported that supporting students was a routine task and they found themselves in the dual role of a nurse and a mentor. This suggests that full support was not given to students and the need to give clear direction to those qualified nurses is crucial. This can be achieved by setting clear objectives, using appropriate learning strategies and acting as a coach with authority for effective learning to take place (Grow 1991:129).

Participants also recognised that they were not qualified mentors and reported that there were constraints in the CLE. It is obvious that they struggle with limited resources to support students' learning. However, this requires willingness and the ability to deliver in a CLE with barriers to mentoring. Nonetheless, the leadership quality of the mentor is crucial in order to fulfil the roles of the coach, motivator, facilitator and consultant, as Grow's (1991) model of self-directed learning builds on leadership.

For the learner to reach the expert level and act as a consultant, they must undergo training and develop mentoring, management, leadership, teaching and educational skills, as shown in Table 4.2. Mentoring in itself is a process, which implies that steps have to be followed. The ultimate aim is capacity building, empowerment and the development of competencies which greatly depend on the collaborative and participatory approach between the mentor and mentee (Seekoe 2014:6). Once in the role of the expert and consultant, the learner will have the ability to use empirical evidence and logical reasoning to understand a situation as a whole and fully get engaged (Oshvandi et al 2016:3017). In other words, as a consultant and expert, the learner moves from being a passive observer to that of being an active doer, which usually occurs over time. This also suggests that there is an increasing level of responsibility from the part of the learner to reach the stage of self-directed learning, and decreasing the level of control on the learner from the part of the teacher. However, Nasri (2017:1) argues that self-directed learning becomes more meaningful with positive experiences for the learner when there is a collaborative relationship established with the teacher.

Thus, Grow's (1991) model promotes the growth of adult learning where the learning process is led by the learner under the guidance and facilitation of the teacher.

6.4 RECIPIENT

The recipient refers to the person receiving the activity (Dickoff et al 1968:422). In this study, the recipients are student nurses enrolled in the DGN programme. As recipients, they are dependent on the agent. The students are novices in the nursing field with no experience and need learning support and monitoring throughout their placement for their fitness to practice. In this study, students highlighted the unavailability of mentors and poor communication. They also mentioned that the ward was not adequately resourced in terms of staff, equipment, and supplies.

Students have an interest in being proactive regarding their learning activities during their placement. This would contribute to a great extent in achieving the clinical placement objectives. In other words, they should progress along the learning continuum, from novice to expert, as Benner (1984) puts it. Along the same line, Grow's (1991) model also views students as being dependent (novice) and then becoming interested (advanced beginner). Thereafter, they get involved (competent) and eventually become self-directed (expert). In this respect, the clinical mentor should support students in enhancing their knowledge, skills, and attitudes. In short, much emphasis should be placed on the cognitive, psychomotor and affective skills of the students during clinical placements.Figure 6.2 illustrates the recipient who is dependent on the agent.

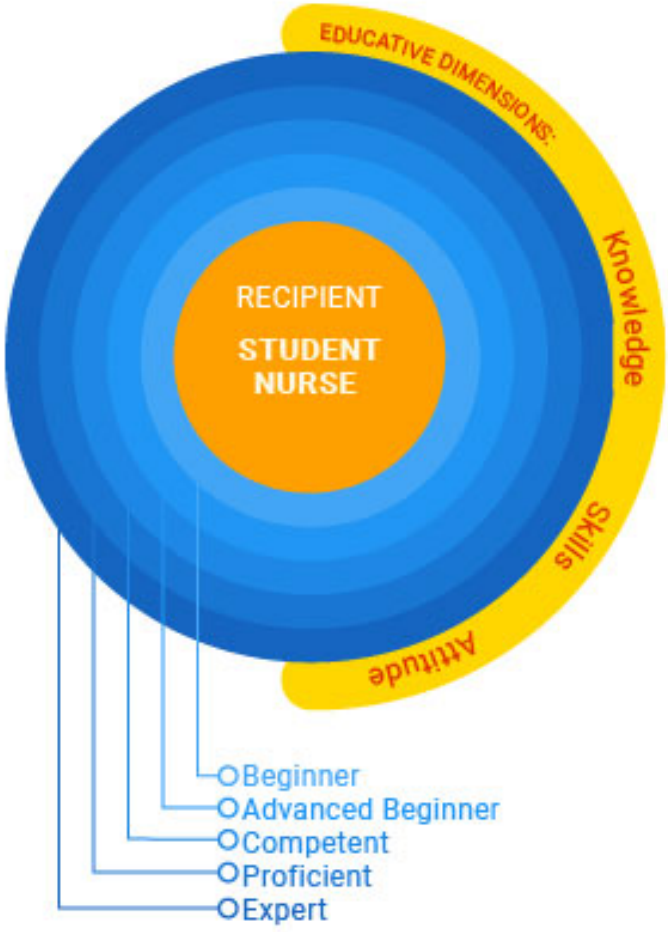

Figure 6.2: The recipient

6.4.1 Knowledge of learning

Knowledge gained by students during their clinical placement forms the very basis of nursing education (Gunay & Kilinc 2018:81).Despite the theoretical knowledge taught at the CNS, Adibelli and Korkmaz (2017:20) affirmed that students should frequently be exposed to pre-clinical orientation before placements so that they can understand how to integrate and further enhance their knowledge. For this reason, students should be self-directed and supported by the mentor (Grow, 1991). Furthermore, the mentor should assist them to apply new knowledge to promote reflection and critical thinking in the context of evidence-based care (El Hussein & Osuji 2017:22). Alternatively, sharing knowledge among peers brings a sense of competition, a feeling of safety and good learning experiences (Stenberg & Carlson 2015:48-55). This, therefore, suggests that students should show a willingness to be personally committed to exploring all learning opportunities to broaden their knowledge.

6.4.2 Skills

Students should receive clinical exposure in a range of clinical settings and simulations in skills labs to acquire the requisite skills (Nielsen, Norlyk & Henriksen 2019:32). The mentor should, therefore, motivate the student to get involved in assisting as many procedures as possible to sharpen their skills. Nonetheless, these procedures should be under constant supervision of the mentor, when being undertaken by the students. This allows the mentor to assess the skill of the student in term of their competency. It is important to decide on objectives of clinical placements together with the mentor, creating learning opportunities, follow-up of clinical training through guidance and feedback, keeping proper records and learning within a multidisciplinary team (Vinales 2015:532). Solvick and Strukness (2018:9) reported that extensive simulation in skills labs reinforces students' confidence; in turn, they tend to perform very well in clinical settings by refining their skills further.

6.4.3 Attitudes

Attitude refers to the affective domain of teaching and learning which require students to demonstrate behaviour that is aligned with professional values (Stephen 2015:320). Some common inherent qualities of students include being respectful, attentive, and inquisitive, being motivated, maintaining a good interpersonal relationship with all staff, and being compassionate in caring for patients (Goldie et al 2015:40). These qualities are also guided by the code of practice of the profession to which the students should abide. This indicates that the students should practice according to standards and within a defined scope of practice to uphold professional values. For example, a key element of the CLE is the participation of students in their learning through teamwork, knowledge sharing and structuring of the learning outcomes while interacting with other health professionals in the CLE (Liljedahl et al 2015:284). Therefore, showing and maintaining the right attitude at the very start of students' clinical placement helps in shaping their professional values.

6.4.3.1 The novice to expert continuum from students' perspective

Students' clinical placements are critical for their professional growth and their fitness to practice. As mentioned, according to Benner (1984), new learners usually undergo five stages which consist of the novice, advanced beginner, competent, proficient and the expert. Additionally, students tend to build on their learning experiences to progress through a learning cycle which involves having an experience at first, then reflecting and learning from it and eventually trying out what has been learned (Kolb 1984:42). The learner needs supervision throughout the continuum of novice to expert to become independent. In this study, participants were third-year students, implying they could be considered as advanced beginners. However, they also pointed out that there was poor interest in supervision and no shared understanding of mentoring. As such, learners also do not have 'life experiences' of how rules are applied as they simply comply with what they have to do (Benner 1984:15). Nonetheless, **novice learners** tend to observe and act according to general rules based on their theoretical knowledge,

while **advanced beginners** make use of their intuition based on learned rules to understand situations (Thomas & Kelgren 2017:229).

The participants' clinical experiences and knowledge would also facilitate and further enhance their practical knowledge and skills. In addition, this can be reinforced under supervision, through the use of simulation exercises which have proved to be an effective tool in the novice and advanced beginner steps (Oshvandi et al 2016:3016). According to Benner (1984:13), as the learner progresses to the **competent level**, the latter tends to prioritise and think in a rationale way by building on acquired skills and experiences to look at situations from a broader perspective to decide about intervention and prepare to take responsibility. Thus, the learner moves on to the **proficient stage**, where the latter views situations in a holistic way, they feel confident and demonstrate the ability to think, plan and interpret. The student therefore has a practical understanding of the situation and uses mainly knowledge, experience, and intuition to merge theory to practice in an **expert role** as an independent practitioner. However, in this study, students reported that mentoring did not promote critical thinking and reflective practice.

The transition from novice to expert contributes to the professional growth of the learner. In this process, the learners are supported by the mentor who supervises and guides them while monitoring their progress. Indeed, not all students are keen and fast learners, as there might be some low performers where the mentor will have to give special support for their fitness for practice. For instance, in this study following up with students was in the form of clinical accompaniment and the need to review the whole learning support system is critical. In addition, the students reported that there was poor communication, feedback and unavailability of mentors. In the novice to expert journey, the joint efforts of both the mentor and the learner determine the expert status of the learner. However, Bowel (2018:1) mentions factors, such as culture, environment, autonomy, technology and education that impact on nurses' ability to achieve expert status. Mentors should therefore consider all these factors, particularly when the learner is moving from one level to the next, such as the competent and proficient stages where

they have a good level of understanding of situations. Attaining the expert stage allows the learner to have certain autonomy and become independent. The findings of this study indicate that it is imperative to support students according to their learning needs and styles to optimise their learning potential to reach the expert level.

Thus, the learner gets involved in becoming self-directed with the help of the teacher who acts as a facilitator (Grow 1991:137). The competent, proficient and expert stages imply that the learner has mastered and is equipped with relevant knowledge and skills, while he is also viewed as a consultant in his field as emphasised by Grow (1991). This means the learner can support peer mentoring.

Arguably, both Grow's and Benner's models require the learner to progress through stages by building on their learning experiences. Learning experiences therefore engage the students in the learning process and also facilitate the integration of theory into practice (Murray 2018:51).

6.5 CONTEXT

The context can be a situation, a milieu, or an environment (Nghipondoka-Lukolo & Charles 2016:176) where the activity is performed (Dickoff et al 1968). According to Ereumegbe (2015:479), an organisational environment is not limited to its physical surroundings but is also influenced by internal and external forces which can either positively impact or hinder its activities. Similarly, it can also be argued that the CLE is influenced by those forces given the complexity of the CLE with its network of forces as stated earlier. An awareness of these forces is therefore crucial for mentors as this allows them to adapt accordingly to both the external or internal forces. However, exercising control on the CLE can be challenging and stressful because of its unpredictable nature (Baraz et al 2015:52). Figure 6.3 shows the context within which both the agent and recipient are mutually engaged for professional growth

Figure 6.3: The context

6.5.1 External forces

With regards to the CLE, the external forces refer to those forces which are seen as being outside the CLE. These forces require particular attention since management and mentors do not have control over them (Euremegbe 2015:484). Participants in this study mentioned the role of the regulatory body, the need to follow the global trend, the use of technology, and the importance of the training institution regarding the mentoring of students in the CLE.

The role of nursing regulatory bodies is to maintain standards in the practice of nursing (RCN 2017). Hence, non-compliance with standards or policies set by a regulatory body could impact negatively on practice. For instance, the NMC (2008) spells out the eight competencies which mentors should demonstrate, as shown in Table 1.1. Most decisions taken by a regulatory body are implemented in the form of policies which are binding because of its legal force (Nursing Council of Mauritius 2003). The need to devise a new mechanism to share best practices and educational approaches to mentorship is vital to maintaining standards (RCN 2015:6). The inputs from the regulatory body tend to reinforce standards of practice and promote professional values,

compliance, and governance through established standards (Duffy 2015:50; Fulton 2015:49). However, the harmonisation and quality assurance of mentoring have been recognised as a challenge in many countries, since standards of practice within the CLE are often below level, as pointed out by Zakaria and Rahman-Gheith (2015:35). Thus, regulating mentoring practice within the CLE ensures that pre-registration students are fit for practice while protecting the public (Hardman 2016:4).

While the practice of nursing shares basic common principles, the profession also changes and evolves at a global level owing to new advancements. For this reason, mentoring should be considered from a broader perspective which is aligned with the complex system of globalisation (Baxley et al 2014:16). For example, in the local context, the global approach to nurse training played a key role with regards to the shifting of the Certificate in General Nursing to DGN so that the training of nurses was aligned with the global trend. It is, therefore, an inevitable fact that globalisation will impact on the profession as nurse training is increasingly being orientated towards pre-registration degree programmes, which would require innovation in clinical mentoring. Nonetheless, the close collaboration of the CLE with the training institutions and the use of technology for the advancement of clinical mentoring should not be overlooked.

With the use of technology, online education has increasingly gained much popularity and contemporary nursing education needs to consider virtual mentoring as a tool for enhancing clinical training (Clement 2018:1). The availability of e-resources in CLEs allows both mentors and students to access updated and evidence-based information that can guide practice, patients' care and learning (Beers & Berry 2015:2).

In addition to the external forces mentioned, the role of an educational institution cannot be underestimated. Establishing collaboration between the CLE and the training institution is a key factor in monitoring good mentoring practice. Douglas et al (2016:37) reported that mentors need support from the academia, link lecturers and practice education facilitators to manage difficult situations during clinical mentoring of students. Academic and practice collaboration models are more effective in offering innovative

approaches to practice training and promoting evidence-based care (Le Flore & Thomas 2016:187; Maxwell et al 2015:43). The training institution and the hospital have an important role in empowering mentors and nurses to ensure effective clinical mentoring. However, in a study in the UK, Foster et al (2015:18) reported that students preferred direct learning support in practice from academic staff.

6.5.2 Internal forces

The internal forces refer to those key factors that are present within the CLE as shown in Figure 6.2. These forces tend to contribute to a conducive CLE, while it can directly or indirectly influence patients' outcomes and clinical mentoring. These forces ensure that the learning needs of students are met. This consist of management support, working culture, policies, guidelines and protocols, competent staff and learning strategies

The support of management was highlighted by the participants in this study and similar observations have been made in other studies. Setati and Nkosi (2017:133) noted that the management and training institution has a lot to gain by recognising the roles of those who are supporting students' learning in clinical settings since this will likely foster confidence, motivation and boost the professional image of those mentors. It is the responsibility of the management to ensure that students receive support from key stakeholders (RCN 2015). Conversely, Traynor and Mehigan (2015:20) concluded that 'key mentors' should be designated to provide support to students and mentors. In addition, they should be knowledgeable about clinical areas and act as a liaison officer between the training institution and clinical settings. It is, therefore, an indisputable fact that management plays a vital role in providing all the necessary resources and other support needed for clinical mentoring and lack of support from management could impede on the practice of clinical mentoring. Thus, management tends to act as a gatekeeper with regards to students' placement and clinical mentoring. However, this is also dependent on the working culture and existing policies and guidelines within the clinical settings.

A working culture is developed over time and always favours good practice. A good practice is enforced when there is a robust system of control to maintain it. In this study, participants pointed out that there was no clear policy or directive regarding the support of students' learning in the CLE. Within the literature, many factors have been identified by both students and mentors which inhibit clinical mentoring in the CLE. This might also be associated with poor management and unwillingness to change practice. Flott and Linden (2016:507) argue that organisational culture is driven by the leadership style of the ward manager, existing ward policies, protocols, and the caring ethos are all factors that can impact on the overall social climate of the CLE. Policies, guidelines, and protocols provide direction for an activity by promoting adherence to standardised practice and compliance to regulation (Irvin 2014:2). Thus, they are useful tools which should be followed to optimise the appropriate practice of clinical mentoring. However, the efficiency of these tools relies also on the teaching strategies in place within the CLE.

6.6 DYNAMICS

Dynamics refers to the internal energy or power sources or motivational factors which drive the activity (Dickoff et al 1968). The dynamics in this study refer to the underlying factors that could drive and sustain an effective mentoring system. An ideal mentoring system is dependent on many factors as identified within the literature, yet the traditional mentoring system does not adopt a philosophical approach. Since the core activity of mentoring revolves around the support of students' learning in clinical settings, it also requires passion from the mentors and students. Spurr, Bally and Fergusson (2010:349) advocate a philosophical approach to education which is passion centred. Figure 6.4 represents the dynamic of the mentoring process.

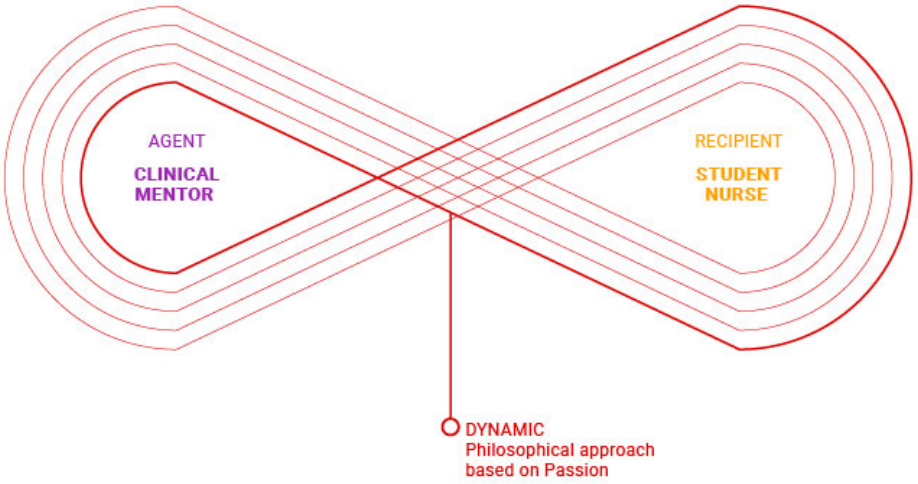

Figure 6.4 : Dynamic

6.6.1 Passion as an approach

In simple terms, passion refers to an extreme interest or wish to do something (Cambridge 2018); it is the love and commitment shown for doing an activity or something. Drawing from the work of Day (2004), Spurr et al (2010:349) purport that the philosophy of nursing education should be based on passion, where the mentor should teach and promote a positive learning environment. When there is 'passion', both mentors and students feel supported, valued, and engaged (Spurr et al 2010:349). The philosophy underpinning Day's model revolves around 'passion' and allows educators to view clinical education from a different angle in response to an ever-changing clinical environment.

This 'passion', along with leadership, is driven with enthusiasm and principles which are based on five dimensions, namely collaboration, commitment, achievement, caring, and trust (Spurr et al 2010:350). The authors believe that these dimensions are paramount for effective learning and teaching, while it can be used as a philosophical approach to leadership in nursing and teaching in clinical education.

6.6.1.1 Passion for collaboration

Participants from both phases of the study highlighted that collaboration was a barrier to clinical mentoring. It is crucial that at the very outset, the student and the mentor agree that they would collaborate at all levels in meeting the learning objectives of the clinical placement. For instance, the mentor can use a range of learning activities to enhance students' learning. This might include collaboration among students to present a case study for discussion or engaging the students to work in partnership with other health professionals. Indeed, collaboration in clinical mentoring tends to establish cohesiveness, flexibility, instils confidence among students, and promotes inter-professional knowledge sharing (Wahab, Iqbal, Wu, Westley, Kanesvaran & Radha Krishna 2016:1). It can also be argued that passion for collaboration tends to reinforce the collective responsibility of everyone to enhance learning towards a common goal. Both the mentor and student are committed to engaging themselves during the mentoring and learning process (Spurr et al 2010:350). Thus, it is evident that collaboration between the educator, mentor, student, and other staff remains a key factor in the learning process.

6.6.1.2 Passion for commitment

In this study, participants observed that both management and nurses were not fully committed to supporting students' learning in the clinical setting. Mentors should have a passion for commitment and show that they are devoted to students' learning. This enables the students to engage themselves emotionally and intellectually (Spurr et al 2010:350). For example, the NHS Education for Scotland (2013) advocates that mentors should be committed to upgrading their knowledge, skills and clinical competence with regards to mentoring. The commitment of the mentor should also relate to his engagement in establishing connectedness at all level for mutual benefits (Schuler 2017:1). However, mentoring involves building a relationship between the learner and the mentor (Houghton 2016:42), and for this reason, commitment from both the mentor and the student to sustain the relationship is key to its success. Clearly,

passion for commitment appears to be a *sine qua non* factor for effective clinical mentoring.

6.6.1.3 Passion for achievement

Achievement should be considered an essential attribute of a nurse educator as the purpose is to provide a fruitful and successful clinical experience to students (Spurr et al 2010:351). Similarly, this implies mentors should demonstrate a passion for achievement with regards to clinical placement objectives, particularly with an emphasis on students' learning and their fitness to practice. Mentors, therefore, have a duty to optimise their efforts in creating a conducive CLE, which fosters the professional growth of students through the acquisition of knowledge, skills, and competencies. It is to be emphasised that the knowledge enhancement of students in clinical settings is commonly achieved through learning activities such as simulation exercise, hands-on practice, feedback, reflection, and critical thinking. However, developing critical thinking skill helps students in their clinical decision making and solves the problem, while it is also a transferable skill that is embedded in the daily routines of a nurse (Ericksen 2017:2).

6.6.1.4 Passion for caring

Caring for patients requires compassion, but mentors should care for the students as well. With regards to clinical mentoring, a passion for caring refers to the creation of a platform within the clinical setting that promotes debate, values, supports students' ideas, encourages discussion and respects students as individuals (Spurr et al 2010:352). This implies that there should be a student-centred approach where the latter is holistically cared for by the mentor. Mentors have a responsibility toattend to all the needs of students so that they are not left on their own. For instance, mentors usually have a caring attitude right at the start towards students during their induction. They are then given special attention regarding their clinical practice and are closely followed as they progress during their training. In their study Joolea, Farahani, Amiri and

Varoei (2016:7) claimed that students should be nurtured. They found that mentors should adopt a humanistic approach towards students, through acceptance, respectful communication, instilling confidence, constant supervision, and empowerment. Thus, caring should be considered as a key element in enhancing a positive, successful learning experience for the students (Spurr et al 2010:354).

6.7 PROCEDURES

The procedure usually refers to how the activity takes place, which is, in fact, guiding rules, protocols or techniques to be followed while the activities are being carried out (Dickoff et al 1968).In other words, it is the steps or processes that give direction to an activity (Nangombe & Amukugo 2016:51). The findings of this study revealed that clinical mentoring was in the form of clinical accompaniment which is commonly conducted by professional nurses who are not adequately trained; they lack teaching and supervision skills (Letswalo & Peu 2015:366). Consequently, this is in contrast to the process of clinical mentoring. Thus, the procedure involves the course of action which should be followed to achieve the goals of the activity (Nangombe & Amukugo 2016:109).In principle, the mentoring process should include the promotion of mentoring (Gallup 2017:1), the training of mentors, pairing of mentors/mentees, setting goals and measuring outcomes (Trees 2017:1; Drahosz 2015:1). This is depicted in Figure 6.5

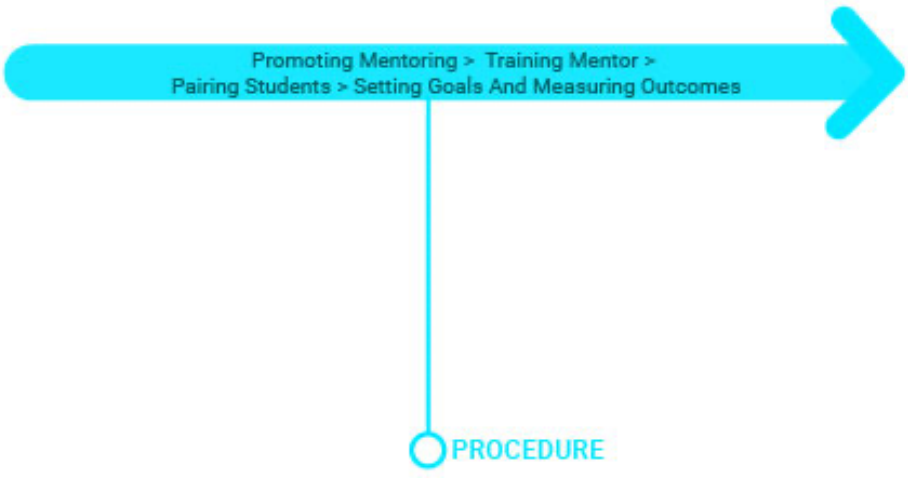

Figure 6.5 : Procedure

6.7.1 Promotion of mentoring

Since the mentoring system in the local context will be a new approach to supporting students in the clinical settings, it is crucial to communicate this new approach to all concerned stakeholders. Moreover, it is the promotion of mentoring in clinical settings. The concerned stakeholders will include management, nurses, students, ward managers, educators and representatives from the regulatory body. This interaction also takes the form of buy-in exercise for broad support which allows a better understanding of clinical mentoring and the rationale for adopting this new approach. Thus, the views and ideas are exchanged in a transparent way for the establishment of the new support system. The promotion of mentoring tends to guide how students' practice-based learning can be effectively supported (RCN 2017). Gallup (2017:1) further asserts that promoting such activity raises awareness among both mentors and mentees with regards to engagement and recognition where everyone undergoes professional development in term of interpersonal, leadership and coaching skills.

6.7.2 The training of mentors

Central to the findings of the study, the training of mentors was identified as one of "the pre-requisites needed for the mentoring process" (Table 1.4), which requires mentors to undergo a short training course in mentorship. Based on the aforementioned discussion related to the agent (Section 6.3), the content of the short course should cover the pedagogical aspects of teaching, learning and assessing in clinical settings. In addition, emphasis should be placed on managerial, leadership, relational and mentoring skills. This training is critical as it will determine the quality of clinical mentoring practice and the standards required to be a good mentor and mentee (Gallup 2017:2). Equally important is that significant attention should be paid to collaborative reciprocal learning where the mentor is seen as the teacher and the mentee as the learner (Seekoe 2014:2). The role of each party should be clearly explained as the training provides tools and techniques so that both mentors' and mentees' potential is enhanced (Trees

2015:2). However, the allocation of students to mentors should be dealt with in accordance with the needs of students.

6.7.3 The pairing of students

The pairing of students with mentors is one of the strategies used in clinical settings to meet the clinical, academic and developmental needs of students (Joubert & De Villiers 2015:1145; Drahosz 2015:2). However, before matching the mentor with the student it is cautious to know what the student's preferences are regarding their learning styles and what qualities the latter seeks in a mentor (Trees 2015:2). Furthermore, matching should be based on a common premise for not compromising the positive outcomes of the mentoring process (Nowell et al 2017:8). Hence, the rationale for matching a mentor to a mentee is to ensure that students are assigned to competent and experienced mentors so that their specific learning needs are addressed. It can also be argued that incompatible matching could be considered as unfair, particularly from students who are low performers. Joubert and De Villiers (2015:1) affirmed that due attention should be given to the allocation and orientation of both mentors and students as good matching fosters positive experiences and promote critical thinking and reflective practice among the students.

6.7.4 Setting goals and measuring outcomes

Setting goals is a key factor for learning to progress and is dependent on the quality of the mentoring relationship between the student and the mentor (Nowell et al 2017:1). A good relationship between the mentor and student helps to clarify and establish each other's roles and expectations, while it also allows them to agree on common goals and objectives (Trees 2015:2). Nonetheless, the goals and objectives should be aligned with the training programme and should be specific, measurable, achievable, realistic and time-bound (Austin 2016:3). Consequently, the aim of setting goals and objectives is to measure whether the outcomes of the practice placement are achieved and it also demonstrates whether both mentors and students have grown professionally (Trees

2015:2). Measuring the outcomes of clinical mentoring usually require surveying both mentors and students, and offering feedback (Gallup 2017:2). This is an important tool which assists in further improving the system. In whatever way, caution should be exercised since all measuring tools have drawn mainly from business and education, while a more robust and specific tool for clinical mentoring is preferable (Chen et al 2016:20).

Likewise, in light of what has been discussed, the procedures should also consider the education dimensions, the context and the dynamics in which clinical mentoring takes place. Mentors should, therefore, follow and systematically consider all the steps that will lead to effective clinical mentoring to take place.

6.8 TERMINUS

According to Dickoff et al (1968), the terminus refers to the endpoint or outcome of the activity. In other words, it is the desired outcome an agent wishes to achieve through the procedures. The terminus of this study is the outcome of all that has been discussed; that is, to deliver competent nursing students as indicated in Figure 6.6 with the necessary knowledge, skills, and attitudes who are fit for practice. The whole process leading to the terminus is summarised in Figure 6.7, which forms the basis of clinical training framework for students' nurses. Likewise, it is also arguably from the framework that both students and the mentors can depart from a beginner base to move on to becoming an expert.

Figure 6.6: Terminus

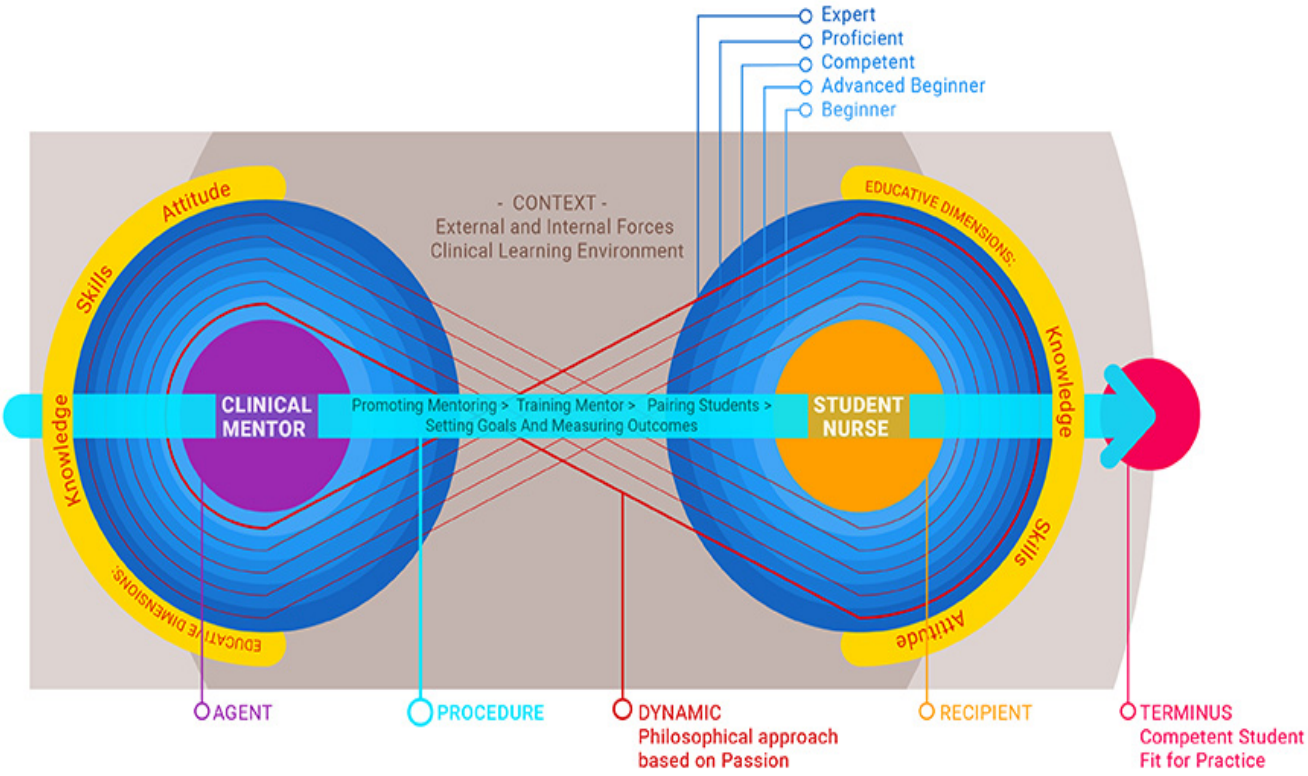

Figure 6.7: A clinical mentoring framework for student nurses in Mauritius

Author's own conceptual framework

6.9 PICTORIAL DESCRIPTION OF THE FRAMEWORK

The clinical mentoring framework for student nurses in Mauritius was developed according to the overall aim of the study. The main concepts were identified from the findings of the study and synthesised to establish links. The rationale was to generate ideas that could provide new insights for the development of the theory. The concepts were examined, defined and grouped according to the six components of Dickoff et al's (1968) survey list.

Figure 6.7 depicts how the six components were integrated to develop the clinical mentoring framework. The rationale for using various colours to illustrate the framework is based on the fact that colours tend to influence thoughts and feelings that are not perceived (Colour Psychology 2018). The following meanings are associated with the colours used in the framework:

- *Purple* – is the colour of imagination and power (Agent).
- *Brown* – represents solid foundation, stability, reliability and wholesome (Context).
- *Red* – colour of passion signifying courage, strength and power.
- *Blue* – signifies communication, efficiency, trust, confidence and authority (Benner's Theory).
- *Orange* – relates to encouragement, motivation and enthusiasm (Recipient).
- *Yellow* – symbolises optimism, clear thinking and wisdom. (Students and mentors desired outcomes).
- *Pink* – represents hope, motivation, safety and optimism (Terminus).
- *Turquoise* – associated with wholeness, wisdom, communication and reflection (Procedure).

This framework attempts to adopt a new approach to mentoring student nurses during their clinical placements, and is schematically represented by the components hereunder.

6.9.1 The context

The *context* is represented by the background in the box within which all the components of mentoring are found. The rectangular shape signifies assurance and stability. The brown colour symbolises solid foundation, reliability and wholesome. It is within this context that clinical mentoring takes place. It consists of the external and internal forces. The external forces include the regulatory body, technology, globalisation and role of the educational institutions. The external forces are from the external environment of the clinical setting. The internal force is comprised of the policies, guidelines, management support, learning strategies and competent staff within the clinical setting. Both internal and external forces are interrelated. Hence, the context provides the very foundation on which the mentoring process is based. This guarantees stability as those factors contribute to a conducive CLE which would likely impact on positive mentoring outcomes.

6.9.2 The dynamic

The figure of eight threads like structure represents the *dynamic* of the mentoring process; that is, the energy and motivational factors required to give impetus to mentoring. The red colour is commonly associated with passion, strength and power which help to trigger emotions and motivate people to act. The red colour also signifies a pioneering spirit and leadership qualities, promoting ambition and determination. For this component, passion was identified as an important power source based on trust, caring, collaboration, commitment and achievement.

6.9.3 The agent and the recipient

Figure 6.8 illustrates the links between the agent and recipient within the CLE, which are depicted by two blue circles on the right and left respectively. The blue colour within the circles relates to communication, efficiency, trust, confidence and authority. Benner's Novice to Expert Theory is represented by the circles and being guided by the

mentor through the stages requires effective communication between the learner (student) and the teacher (mentor). This creates trust and a sense of confidence among the students until they become independent. The link between the two circles also indicates the mentor-mentee relationship and how Benner's (1984) novice to expert stages provides the right pathway to the acquisition of knowledge and skills for the students. Thus, students develop a sense of security and feel ready to take responsibility.

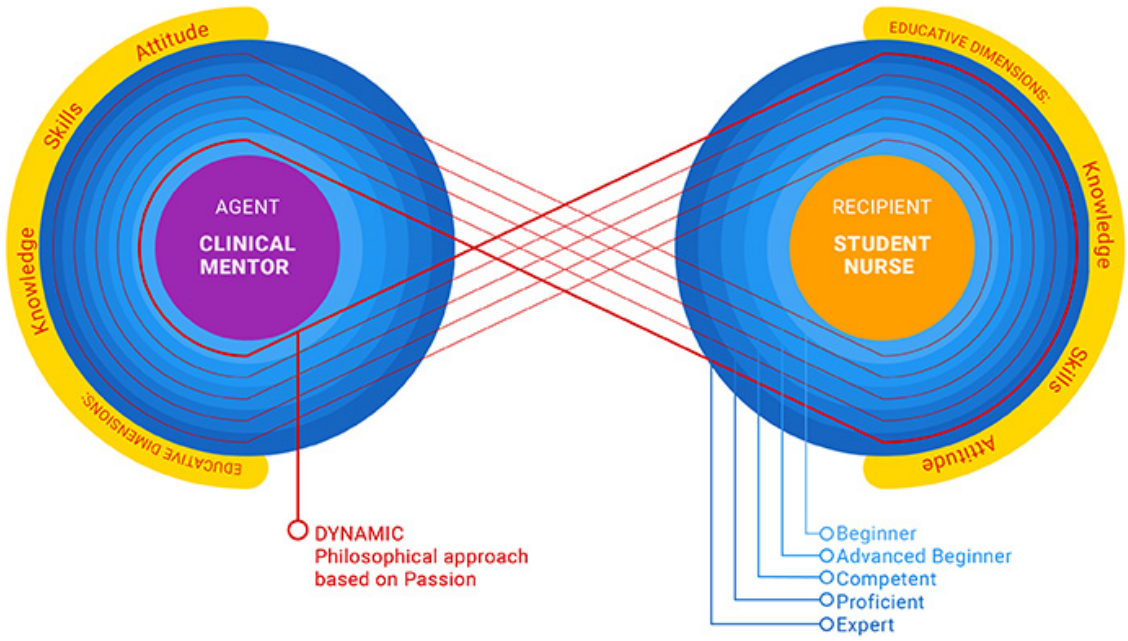

Figure 6.8: The agent and the recipient

Both the agent (mentor) and the recipient (student) are represented by two distinct circles. These circles imply wholeness; it depicts the desired goals of the mentor and the student. The orange circle represents the recipient which symbolises encouragement, motivation and enthusiasm, while the purple one represents the agent which relate to imagination, wisdom and enlightenment. The yellow part of both circles depicts wisdom, clear thinking and optimism. Mentors should be knowledgeable and competent to empower the students to take responsibility for their own learning to

become independent and self-directed. It is the teaching, assessing and learning skills along with experiences which will likely transform the expert mentor into a consultant. Likewise, knowledge, skills and attitude are also key elements that shape the professional growth of both mentors and the students.

6.9.4 The process and terminus

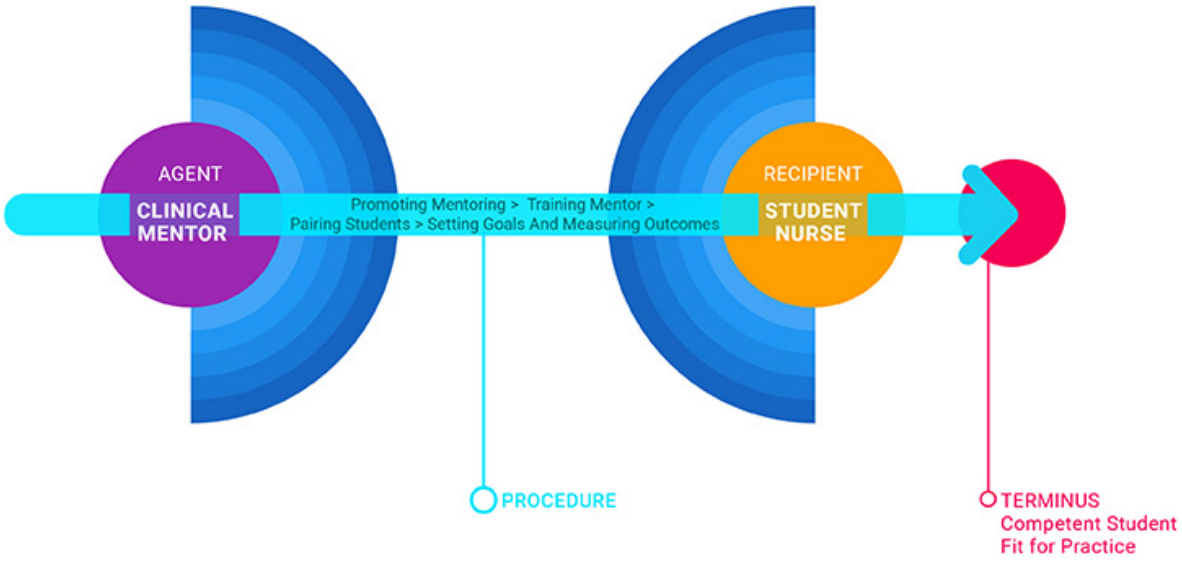

Figure 6.9: The process and terminus

Figure 6.9 shows the process that leads to the terminus, which is the final outcome of the mentoring process. The *procedure* is represented by a small turquoise rectangular box which signifies wisdom, wholeness and creativity. This depicts how the practice of mentoring could be enhanced. It gives direction on how to promote mentoring, train mentors, pair students, set goals and measure outcomes. The commitment and trustworthiness of all stakeholders are critical for the mentoring process. The mentors need to innovate by encouraging the students to be self-directed and optimise their potential through the use of new learning strategies such as e-learning. The end point of the mentoring process is to train students who are competent and fit for practice. This is

represented by the pink circle which symbolises pre-registration students who are equipped with the necessary knowledge, skills and attitudes to deliver safe and compassionate care to patients. The terminus also implies that the training of the students has been streamlined and is in accordance with the agreed goals of the mentor and student.

In view of the aforementioned framework, the focal point was on the concept of clinical mentoring and its variables. This has unfolded a new approach to mentoring. It also proves that the mentoring process is not linear, but requires both vertical and lateral thinking for a holistic approach. Since it has not been implemented, its appropriateness and usefulness cannot be judged at this stage. Nonetheless, this framework provides insights and gives direction about how mentoring can be improved and practised in an effective way.

6.11 SUMMARY

The main focus of this chapter was on the development of a framework for clinically mentoring student nurses in Mauritius, based on the findings of both phases of the study. This framework was conceptualised using Dickoff et al's (1968) survey list. The various concepts were identified from the findings of the study and described to establish relationships. The use of the survey list proved to be a useful approach in structuring the conceptual framework and all the activities related to the agent, recipient, context, dynamics, procedure, and terminus were considered from a broader angle. The conceptual framework would form the basis of how clinical mentoring should be practised in clinical settings. It is envisioned that this clinical mentoring framework will facilitate a new approach to clinical mentoring, especially in the context of the DGN. The next chapter that follows will summarise the key findings, evaluate the framework, and provide conclusions and recommendations.

CHAPTER 7
SUMMARY OF KEY FINDINGS, EVALUATION OF THE FRAMEWORK, LIMITATIONS, CONCLUSIONS, AND RECOMMENDATIONS

7.1 INTRODUCTION

The central phenomenon of this study is related to mentoring. Mentoring is said to be a global strategy to support students' learning in clinical practice. Currently, student nurses in Mauritius are supported by qualified nurses during their clinical placement which is a rather informal way of mentoring students. The purpose of the study was to develop a contextually relevant clinical mentoring framework for student nurses in Mauritius to enhance the standard of student nurses' training during clinical placements. The main focus of this research was to elicit the views of both students and nurses with regards to mentoring and to identify and describe those factors that promote or hinder effective mentoring.

Chapters 4 and 5 paved the way for the development of the conceptual framework for clinical mentoring as described and discussed in Chapter 6. This chapter will briefly summarise the research methodology used, the key findings of both phases of the study, the process involved in the development and evaluation of the framework. The limitations of the study will be addressed, and recommendations for practice and further research will be provided.

7.2 RESEARCH DESIGN AND METHODS

A descriptive exploratory sequential mixed method with a cross-sectional design was used in this study. The mixed method allowed the researcher to capture the wholeness of the phenomenon from different angles, which a single approach would not have provided. The mixed method also involved data integration from both sources. Data in the first phase of the study were collected from nurses through face-to-face semi-structured interviews, while the second phase involved the use of structured

questionnaires to survey both students and nurses. The sample size for the qualitative phase was eight and for the second phase was 255 nurses and 155 students, respectively. A thematic analysis was used to analyse qualitative data while both descriptive and inferential statistics were applied to the quantitative data. Every step was undertaken to ensure rigour throughout the conduct of the study. The key findings of both phases are briefly presented separately hereunder.

7.3 KEY FINDINGS OF THE QUALITATIVE PHASE

The qualitative findings indicated that the currents support system for students in the clinical settings was mostly informal and did not reflect what mentoring should be about. Mentoring, *per se*, was not practised but rather a form of clinical accompaniment resulting in the practice being less effective for its purpose. A variety of activities/roles were described that nurses fulfil in everyday clinical practice that included some aspects of a mentoring approach. Participants also provided a number of pre-requisites needed for the mentoring process. The key highlights of these themes are presented hereunder.

7.3.1 Mentoring in the form of clinical accompaniment

Students' learning was supported by qualified nurses, which formed part of their scheme of duties. Although there was an awareness of what mentoring was, there was a lack of policy directives which directly impacted on its standards of practice. Moreover, the participants confirmed that there was no uniformity in the way students were being mentored; that is; they were simply being followed by nurses during their clinical placements. This takes the form of direct support to students without an emphasis on teaching. Consequently, this approach tends to overlook the holistic approach to clinical mentoring of students.

The clinical accompaniment has therefore been a long-established system in the local context regarding the learning support of students in clinical settings. This draws from the fact that nurses have considered it as a routine task which has remained static to

form part of their working culture. In principle, nurses are clinically task-orientated and participants reported that at time, they found themselves in a dilemma owing to their dual role as a carer and a mentor. Many factors have also contributed to promoting the practice of clinical accompaniment. Among other factors identified in this study were the lack of resources and training of mentors, staff shortage, the time factor, lack of recognition and poor consideration to mentoring students. Participants also reported an absence of commitment from management and a lack of motivation from staff to support students' learning.

7.3.2 A variety of activities/roles performed in clinical practice

The absence of a clear policy regarding mentoring students in the local context led nurses involved in supporting students, to be reliant on themselves. Likewise, they were not being monitored by the management or by the school in terms of the way they were supporting students. In short, due consideration was not being given to them in spite of the fact they were fulfilling their roles as carers and multitasking with regards to mentoring. For instance, they were supervising, guiding, coaching and facilitating students during their clinical placements. However, the range of activities performed did not equate mentoring, since the mentoring process requires teaching and assessing skills.

Hence, participants were just complying with what has been practised by their seniors for decades. This lack of a mechanism to oversee the quality of the clinical training of students and its outcomes can negatively impact the learning needs of students. Furthermore, teaching and assessing were not being conducted by the nurses, despite it being considered as two essential activities of mentoring.

7.3.3 Aspects of the mentoring present

Support was informal and undervalued, yet some aspects of mentoring were present. In this study, the relational aspects, the promotion of learning and the documentation of all

nursing procedures were observed by those nurses who were supporting students during their clinical placements. This indicates that the experienced nurses were committed to orient and prepare the novice students for their professional developments to become proficient and competent. The professional relationship forms part of the mentoring process, and the nurses shared their knowledge and experience to nurture the relationship which was based on trust and respect. Thus, qualified nurses were seen as role models and instructors.

The mentor and mentee interaction to promote learning are critical to engaging students in their learning. Although the nurses were involved in some sort of teaching, and while documentation was followed, it is to be noted that it was done as a routine task. Nonetheless, this puts into question the quality of the mentoring, given they were untrained mentors and were not guided and supported by the CSN. In anticipating the learning needs of students, working according to the learning outcomes of the programme is crucial for the successful outcome of clinical placements of students.

7.3.4 Pre-requisites needed for the mentoring process

This theme relates to how the actual mentoring system could be improved in response to the findings. For effective mentoring to take place, participants felt there was a need to focus on policy and directives to all stakeholders, the training of mentors, clinical settings requirements, the mentor's role, and students' responsibilities. This also draws from the fact that mentors have an important role and responsibility towards the students. The mentors, along with the educators, should always ensure that the students are fit for their purpose, fitness, and award (RCN 2017). This means that the students are ready to function effectively in practice, meet the requirements for registration, and have the in-depth knowledge to qualify for the award.

Although all nurses supported students' learning directly or indirectly in an informal way, they need guidance and supervision. They must undergo training to be familiar with the formal mentoring process. The management and school should work together to

provide a conducive CLE which will promote the professional growth of the students. Likewise, both the mentor and the student have a duty to fulfil their responsibilities for the positive learning experience and positive experience of the clinical placement.

7.4 RESULTS OF THE QUANTITATIVE DATA

The quantitative approach relates to Phase 2 of the study. The findings draw from two main sections, primarily B and C of the questionnaires, which were administered to both students and nurses. Section B covered the current practice of mentoring, while Section C captured the essence of the CLE which encompasses elements of ward organisation, communication and relationships, mentoring, and barriers to mentoring within the learning environment. The key results are summarised next.

7.4.1 Current practice of mentoring

This section of the questionnaire sought to elicit both nurses' and students' views regarding the current practice of mentoring. The questions were based on important aspects of how mentoring was carried out by qualified nurses. Slightly more than half of the nurses (53.7%; n=137) and a large percentage of students (76.5%; n=88) stated that there was no mentoring system. Mentoring was also considered informal by nurses (31.0%; n=79), and both formal and informal 36.1% (n=92) as well. In contrast, only 2.6% (n=3) of students believed that mentoring was formal, while 26.1% (n=30) stated it was informal. Around 27.8% (n=32) of students considered it was both formal and informal and 43.5% (n=50) were uncertain whether it was formal or informal.

The learning needs were found to be met to a small extent among nurses (45.1%; n=115), while students (38.3%; n=44) felt it was met to a very limited extent. Nearly all students (99%; n=114) observed that educators' visits were infrequent, along with 70.4% (n=81) of nurses who also maintained that they never had visits from educators. A majority of nurses (86.3%; n=220) and students (91.3%; n=105) asserted that mentors need training.

There were marked differences in the views on failing students. While 35.3% (n=90) of nurses stated they would fail students, 36.9% (n=94) also responded they would not fail students, followed by 14.9% (n=38) who were uncertain. Of the various skills needed by mentors, 88.7% (n=102) of students listed teaching as being the topmost skill, followed by interpersonal skill (71.3%; n=82), counselling skills (61.7%; n=71), leadership skill (42.6%; n=49) and managerial skill (26.1%; n=30).

7.4.2 The clinical learning environment (CLE)

The CLE has been described as a network of forces within which mentoring takes place. This section of the questionnaire included all the factors that tend to influence the CLE and consisted of Likert scale responses. Overall there were 63 items which were categorised into four parts. These items were related to ward organisation (12 items), communication and relationship (13 items), mentoring (22 items), and barriers to mentoring (16 items). The key findings are described next.

7.4.2.1 Ward organisation

The highest mean scores for students (M=4.06 SD=1.372) was on the item “ward orientation of the students is the responsibility of the ward manager” and lowest mean scores (M=1.50 SD=1.360) was on the item “the ward is adequately resourced in terms of staff, equipment and supplies (consumables- gauze, syringes, gloves, ect)”.The nurses’ highest mean scores (M=4.27 SD=0.863) was on the item “the support of management is important to effective mentoring in the ward” and the lowest mean scores (M=3.00 SD=1.319) was on the item “the ward is adequately resourced in terms of staff, equipment and supplies”.

7.4.2.2 Communication and relationship

The highest mean score for students was (M=3.11 SD=1.515) for item “a mentor is a good professional role model” while the lowest mean score was (M=1.41 SD=1.407) for “mentors are available and accessible when required”. In contrast, the highest and lowest mean score for nurses regarding the same items were (M=3.75 SD=1.041) and (M=2.73 SD=1.271), respectively.

7.4.2.3 Mentoring

The highest mean scores for students and nurses were (M=3.38 SD=1.496) and (M=3.55 SD=0.946) respectively with regards to “mentors must communicate responsibilities to students”. The lowest mean score for students (M=1.77 SD=1.590) was associated to item “mentors allow students to practice independently through reflection once they are independent” while for nurses (M=2.47 SD=1.441) was related to the item “mentors are allowed special time to mentor students”.

7.4.2.4 Barriers to effective mentoring

The highest mean score for students and nurses were (M=4.26 SD=1.132) and (M=3.98 SD=0.980) respectively concerning “staff shortage”. The lowest mean score for students was (M=3.55 SD=1.320) regarding “autocratic and inflexible approach of mentors” and that for nurses (M=3.21 SD=1.256) relating to “negative attitude of mentors”.

7.5 CONCLUSIONS OF FINDINGS OF BOTH PHASES

Findings indicated that the learning support provided to students was in the form of clinical accompaniment rather than mentoring. Aspects of mentoring were present, but participants had to adjust to their role of being a mentor through a variety of tasks and activities. In addition, constraints that were identified include a lack of resources in terms of staff, inadequate equipment, crowded wards, a big number of students in

wards, and lack of support from management and school. Both students and nurses recognised that the mentoring system was informal and learning needs were largely unmet. It was also noted that it is imperative to have trained mentors with a separate career pathway. Effective ward organisation is critical to the professional development of both nurses and students, and the ward manager has a key role to play in fostering a conducive CLE. Students shared that there was poor attention given by mentors with regards to communication and relationship aspects of the mentoring process. This included feedback, open discussion, and accessibility. Similarly, students also found that learning was not planned according to learning outcomes and mentors did not promote the use of evidence-based practice and technology. In addition, students thought that the desired skills for mentoring should include teaching, assessing, communication, managerial and leadership skills. It was also found that failing a student is not an easy decision for a mentor.

7.6 DEVELOPMENT OF THE CLINICAL FRAMEWORK

The development of the clinical mentoring framework was based on the findings of the study. The survey list of Dickoff et al (1968) guided the conceptual formulation of the clinical mentoring framework. This survey list provided direction and focused on six components associated with an activity. This included the agent, recipient, context, dynamic, procedure and terminus. Each element was explored at an individual level concerning the mentoring process and relevant concepts were identified from the findings and the literature. The concepts were brought together to establish relationships according to the components for the conceptualisation of the clinical mentoring framework. In short, the structure of the framework with its related concepts allowed for a better and broader understanding of the phenomenon under study and it also demonstrated the steps followed to achieve the end results. Once the structure of the framework was conceptualised, it was also subjected to evaluation.

7.7 EVALUATION OF THE FRAMEWORK

The clinical and scholarly usefulness of theories related to models or frameworks is best assessed through analysis and evaluation, which also enlightens clinicians and scholars about how things work (Risjord 2018:1). The conceptual framework was presented to a panel of key stakeholders for evaluation and validation. Stakeholders included the Director of Nursing, the Principal of the CSN, members of the Nursing Council, the President of the National Nursing Association and a Senior lecturer in Nursing from a private institution (see Annexure I).

The evaluation exercise aimed to understand how the conceptual framework was structured, what the various concepts were, and how they were related. The evaluation exercise was based on pragmatic and epistemic criteria as outlined by Risjord (2018:9). Pragmatic criteria are mainly concerned with the model or framework of the study, its context and the researcher himself or herself, while epistemic criteria assess the model or framework in terms of its scientific knowledge (Risjord 2018:7). The author states that the two criteria are further divided into sub-criteria as follows:

7.7.1 Pragmatic criteria

- ***Usefulness*** – This criterion seeks to ask whether the model or framework is relevant to the outcome of the study and the research question. The conceptual framework of this study was developed following the findings of both its qualitative and quantitative phases. This was presented through interpreting and discussing the findings in Chapter 4 and Chapter 5, respectively, and emphasis has been placed on its significance. It is envisioned that this framework is likely to be useful as it will promote skills, expertise, and talents among both mentors and students. The panel members were unanimous that it will be an important tool to support and sustain students' learning in the clinical setting.

- ***Abstraction*** – This criterion relates to whether the framework has overlooked any important aspects of the phenomenon. The conceptualisation of the framework was based on the survey list as described by Dickoff et al (1968:434). This survey list guided the researcher to capture all the essential aspects of the phenomenon. However, Risjords (2018:8) argues that a model or framework tends to disregard elements at the expense of something, thus implying that it devalues things to value others. On this criterion, the stakeholders noted with satisfaction that emphasis was placed on both students and mentors with regards to their knowledge, skills and attitudes. However, the Lecturer and the Principal Nurse Educator pointed out that, irrespective of all the components of the framework, mentors should have in-depth knowledge in pedagogical aspects of teaching and learning, particularly assessment.

- ***Values*** – As a criterion, value refers to the social context of nursing science. Thus, values should be embedded in the framework, as Risjords (2018:8) puts it. With regards to this criterion, the stakeholders sought clarification as to whether the framework promotes professional values. The researcher asserted that both mentors and students should demonstrate and observe professional values as this is integrated within the framework. They stressed that values should include compliance with standard practice, interpersonal relationships, and the notion of caring for patients within the CLE.

7.7.2 Epistemic criteria

Operationalisation and Precision – This implies whether the elements of the framework are observable and measurable, and precisely how it leads to a meaningful test (Risjords 2018:8). In other words, this refers to whether the framework can be tested. The concepts that led to the development of the framework were observable and measurable. Moreover, the elements within the framework also denote and can predict how one element can change the other. However, the reliability of the framework cannot be assessed, unless it is implemented.

Empirical and theoretical support – The conceptual framework has not been subjected to tests, although it has theoretical support which was based on the findings of the study and other research sources. Hence, it cannot lend itself for empirical support so long it has not been tested. The theoretical support of the framework draws mainly from the concepts which were described and explained from the literature and the descriptive data. Relationships between and among concepts were established for the researcher to gain a better understanding of the concepts which provided a structure of the framework. This usually presents a clearer picture of the links between major and individual concepts in a structured way.

While the mentioned criteria provide a comprehensive approach for theory evaluation related to models or frameworks, Chinn and Kramer (1995:117) emphasised better understanding of a model or framework. Accordingly, it is crucial to lay emphasis on its clarity, simplicity, generality, accessibility, and importance.

- ***Clarity*** – The concepts were identified following the literature search and analysis of both qualitative and quantitative data. Meanings were ascribed to the concepts derived from all sources of the literature and the experiences related to the concepts under study.
- ***Simplicity*** – This refers to whether the framework is complex. As shown in Figure 6.2, the concepts and their relationships leading to the outcome can be easily followed and recognised.
- ***Generality*** – This conceptual framework was formulated to respond in an effective way to the learning needs of the local student nurses during their clinical placements. However, it can be transferable to other similar settings where mentoring is in the form of clinical accompaniment.
- ***Accessibility*** – This framework will be made available to all stakeholders who have an interest in nursing education and policymakers who decide on the orientation of nurses' training. It will also be disseminated through workshops and seminars.
- ***Importance*** – This relates to its practicability with regard to nursing education. As highlighted earlier, this framework will be an important tool for implementing

mentoring in a formal way, while adding a new dimension to the clinical mentoring of students.

The following points were raised during the exercise, which were mainly related to the usefulness of the framework:

- "*For implementing this framework it should be disseminated at hospital levels and ward managers should see there is a conducive CLE"*.
- "*As per this framework it is important to raise awareness among students regarding their responsibility and Nurse educators have an important role to play".*
- *"Full support will be given to this commendable initiative and I will ensure there are coordinated efforts".*

This evaluation exercise was a first of its kind for the panel members. Hence, they were provided with the criteria list, but acknowledged that the epistemic criteria were too abstract. The session was interactive with a verbal exchange of questions and answers which were noted. While Risjord's (2018)model offers an alternative method of evaluating, the framework does meet Chinn and Kramer's (1995) criteria as explained earlier. On the basis of the feedback, major changes or adjustments were not required for the framework. In general, the framework was positively accepted by the panel members who represented the whole nursing profession.

7.8 LIMITATIONS

This study was conducted in five regional hospitals in Mauritius where students were based for their clinical placement. Nonetheless, its findings cannot be generalised to other clinical settings. It is unlikely that all relevant articles from the search have been captured, as some pertinent articles might not have been considered. Students were excluded in the first phase of the study since the researcher was familiar with them and was a trainer at the CSN for the DGN programme. This could have potentially influenced their responses during the interviews while influencing the design of a

different questionnaire for the second phase of the study. The non-inclusion of first- and second-year students in the second phase could be a source of bias, as the views of all students as a whole were not considered. In addition to the presence of a male researcher, the views of more male than female nurses in this study could, to some extent, influence the responses since nursing is a female-dominated profession. Although the study was carried out in all public regional hospitals, data were not collected from nurses working in private and specialised hospitals. Since the results of this study are not generalisable, it may be transferable according to the context of the study. Moreover, while the clinical framework has not been tested, it adds to the existing body of knowledge. Despite these limitations, the findings of this study reflect, to a great extent, what other international studies have uncovered on mentoring.

7.9 RECOMMENDATIONS

The clinical placement of students is an important aspect of nursing education and has a major bearing on their fitness to practice. This is dependent on the mentoring system within the CLE, which takes the form of practice-based learning. The principal goal is to ensure that students can integrate theory into practice, are exposed to patient-centred care and can master a range of skills in various settings. Thus, mentoring maximises the learning opportunities which allows students to develop the required competencies to deliver safe and effective quality care. However, positive learning experiences are also influenced by a conducive CLE and the mentoring system in place. This study identified many factors and challenges faced by Mauritian nurses within the CLE. It has also brought to light the real picture of mentoring in the local context. Based on the conclusions drawn, recommendations are made to address those factors and challenges, particularly in the context of the recent introduction of the DGN. Two main areas are considered with regards to the recommendations, namely research and nursing education.

7.9.1 Recommendations for research

It emerged from the findings that there was poor attention given by the CSN concerning students' placement. According to the literature, most studies on mentoring have been conducted either from nurses' or students' perspectives. This study also attempted to explore the phenomenon from both viewpoints. Mentoring will continue to be a major challenge in the local context with the advent of the new DGN programme and future reform in training and nursing education. From a methodological perspective, it would be interesting to explore the perception of nurse educators on mentoring in the local context using an appreciative inquiry approach. This approach could illuminate the positive aspects and core of "what works in organisations and people" (Hung 2017:1).

The literature also suggests that mentoring cannot be dissociated from the CLE. The CLE can be considered as a highly interactive platform where practice-based learning takes place under the guidance of the mentor. However, it has never been explored as a concept. Further research should investigate the CLE along with concept analysis, as the CLE has greatly evolved with the ongoing global changes regarding nursing education, especially in the context of pre-degree registration programmes. This can further guide systematic and rigorous inquiry while anticipating a more comprehensive definition of the concept and its understanding.

The literature shows that assessment has been identified as a challenging issue in terms of mentors' evaluation of students in clinical placements. Similarly, in this study, the views of mentors varied regarding assessment skills, particularly when taking a decision on whether to fail a student. Students' assessment is a researchable problem which can be investigated from a broader perspective using a mixed-method design to capture the problem in a holistic way. Perhaps this could unfold important factors that influence mentors' aptitudes regarding assessment and the barriers that prohibit mentors from failing students.

7.9.2 Recommendations for nursing education

Since the nursing curriculum is based on fifty percent of theoretical and fifty percent practice training, there must be adequate coordination from all stakeholders for positive mentoring outcomes. There should be an agreement among concerned stakeholders in the form of a policy regarding the learning support of students in the clinical settings, which will give clear direction to mentoring. This will spell out the role, responsibilities and firm engagement for their full commitment in sustaining quality mentoring in clinical settings.

Training is the cornerstone for the professional development of all professionals. Indeed, nurses should be trained and hold an appropriate qualification to exercise as a mentor. The training programme should be a comprehensive one, which also addresses all the pedagogical aspects of mentoring. Moreover, the theoretical training of students should cover the fundamentals of mentoring so that they understand its implication with regards to their training.

Mentoring should be considered as a separate career pathway. This will give formal recognition to mentors who will feel valued and motivated as well. Consequently, this will likely attract more nurses to embrace a career as a mentor. Mentors will be able to dedicate more time to students rather than being in the dual role of a carer and a mentor. This will also ensure that all clinical settings have mentors who are always available and accessible to conduct proper follow-up with students.

Effective clinical mentoring is dependent on many factors. It is paramount that there is an established partnership between the school, clinical placement, and management. To maintain this linkage, the nomination of an educator as a clinical placement coordinator is critical. His role as a liaison officer will allow better management of all aspects of practice-based learning.

The regulatory body has a key role to play regarding the monitoring of standards of clinical placement. Standards have to be set with regards to the desired competencies required for mentors. Specific requirement will include annual mentor updates conducted preferably at universities to enable mentors to keep abreast with their skills, knowledge, and competence. This will pave the way for mentors to be fully engaged as lifelong learners. It is also crucial that mentoring programmes are reviewed according to context and rigorous selection should be observed regarding the selection of mentors and students.

The use of e-learning is an important means to reach maximum learners with regards to their convenience. Many health professionals are increasingly making use of their smartphones in clinical settings to communicate and stay abreast of the latest trends in medicine. Similarly, both mentors and students should make effective use of e-learning to maximise learning and stay updated for positive mentoring outcomes. Not only will connectedness be maintained but, more importantly, the mentor can be easily accessible and the mentor-mentee relationship will further be reinforced.

Adequate resources are also at the heart of learning support for students as it sustains quality mentoring. These resources include human, physical and financial resources. Management should make financial provision while budgeting, by considering the ward as a learning organisation. The budget should cover equipment, staffing, training, workshops, and recruitments to respond effectively to the learning needs of students.

7.10 CONCLUDING REMARKS

In this study, the phenomenon of mentoring was studied in five regional hospitals in the local context. The findings support the importance of students' learning during clinical placements. The learning process in nursing is unique in the sense that fifty percent consists of practice-based learning. Although mentoring is differently exercised across clinical settings, the basic principles should at least be observed despite there being no universal standards on mentoring. However, what constitutes standards of practice for

mentoring needs to be debated and agreed by academics, regulatory bodies, practitioners and professional nurses' associations. The ever-changing healthcare environment directly affects the suitability and adaptability of clinical placements in relation to mentoring, and the CLE remains at the epicentre of mentoring.

Maintaining standards and consistency in mentoring is challenging owing to various barriers within the CLE; however, it remains the only tool which can shape the quality of practice-based learning. The conceptual framework presented in this study provides a broad view of the factors that influence mentoring and how it could be perceived as complex. It can be implemented and tested for further research. Thus, it can also assist all stakeholders in considering the educational needs of students from a holistic perspective. It is therefore fundamental for all stakeholders with an interest in nursing to have a better understanding and recognise that mentoring is an important tool which will help in the training of the next generation of a competent nursing workforce.

7.11 PERSONAL REFLECTION

The central theme of this thesis revolved around mentoring. The literature indicated there is no universal definition of mentoring. The development of the clinical mentoring framework was the real "*bolt and nut issue*" of this long, tireless journey. While embarking on this journey, there was some degree of uncertainty in terms of the great and endless effort which is required of a Doctoral student, and whether I would likely reach the end. The research proposal stage really instilled that confidence to continue the journey following the connectedness with my promoter. My promoter has been consistent with regards to professional and ethical standards throughout this thesis. There were no compromises on her feedback; at times, I was being whipped by some of her comments. Feedback presented a moment of suspense and anxiety, particularly when the work was irrelevant and I had to start from scratch. What I can discern from her supervision is that students should not only take note of the feedback they receive but also be able to decode the real expectations of the supervisor in the comments and remarks.

This journey has also shown me how nurses were struggling to support students' learning in under-resourced clinical settings. Overall, navigating through this journey has been an enriching experience and a challenge. My approach to reading, understanding and analysing articles has further been reinforced. This study has also enhanced my academic writing and critical thinking skills. The interview process and the data analyses were daunting exercises, and the writing process was tedious. From this phase, I learned the importance of experiential learning and how to remain patient without any frustration or irritation. The decision to embark on this PhD nursing programme remains one of my most significant undertakings on the learning continuum.

This study adds to the existing body of knowledge related to mentoring, a new CLEI, and a new clinical mentoring framework. At certain points, I was so immersed in the study that it was not easy to reconcile my work, study and family life. The constant support and motivation of the promoter made all the difference. As a researcher, this journey has positively contributed to my professional growth since it has shaped my way of thinking, I have developed new skills and gained new attitudes.

7.12 SUMMARY

This study attempted to explore mentoring as a phenomenon which was not previously investigated in Mauritius. The results confirmed that mentoring in the local context was informal and a form of clinical accompaniment. This chapter has briefly described the design, methods and the findings of the study. The process involved in the development of the clinical mentoring framework has also been briefly explained, and an outline of the evaluation procedure has been presented. Concluding remarks and limitations of the study were drawn, accordingly. Based on the findings, recommendations were made with regards to future research mentoring and education.

REFERENCE LIST

Adhabi, E & Anozie, CB. 2017. Literature review in qualitative research. *International Journal of Education* 9(3):86-97.

Adibelli, S & Korkmaz, F. 2017. *The factors affecting nursing students' learning in clinical practice*. Annual worldwide Nursing Conference:Turkey.

Agudo, JM. 2016. What type of feedback do student teachers expect from their school mentors during practicum experiences; the case of Spanish EFL student teachers. *Australian Journal of Teacher Educ*ati*on* 45(5):36-51.

Akaranga, SI & Makau, BK. 2016. Ethical considerations and their applications to research case of the University of the Nairobi. *Journal of Educational Policy and Entrepreneurial Research* 3(12):1-9.

Akhigbe, T. 2018. Cognitive behaviourism and experientialism in emergency medical training: From theory to practice in a teaching hospital. *International Journal of medical reviews* 5(3):87-89.

Al- Hamdan, Z, Fowler, J, Bawadi, H, Noorie, P, Summers, L & Debbie, D. 2014. Student nurses' perceptions of a good mentor: a questionnaire survey of student Nurses' in UK, USA and Jordan. *International Journal of Humanities and Social Science* 4(3):248-255.

Ali, WG, El Banan, SHA & Al Seraty, WH. 2015. Effective clinical learning environment as perceived by nursing students at Al Dawadmi Applied Medical Sciences College:Actual preferred versus preferred characteristics. *International Journal of Nursing Didactics* 5(5):1-6.

Aliakbari, F, Parvin, N, Heidari, M & Haghani, F. 2015. Learning theories application in nursing education. *Journal of Nursing Education and Health Promotion* 4(2):1-14.

Al Qahtani, S. 2015. Students' knowledge of and attitude toward mentoring: a case study at the master's programme in health and hospital administration. *Advances in Medical Education and Practice* 6:149-152.

Alkhouri, O, Alkhatib, AJ & Khawafah, M. 2016. Importance and implementation of nursing documentation:Review study. *European Scientific Journal* 12(3):101-104.

Alshenqeeti, H. 2014. Interviewing as a data collection method: a critical review. *Journal of English Linguistic Research* 3(1):39-44.

Amukugo, HJ, Jooste, K & Van Dyk. 2015. Development of model to facilitate male involvement in the reproductive health context by registered nurses. *Journal of Advanced Nursing* 4(2):122-130.

Anarado, AN, Agu, GU & Nwonu, EI. 2016. Factors hindering clinical training of students in selected nursing educational institution in southeastern Nigeria. *Nursing Education Today* 16:1-20.

Arifin, SRM. 2018. Ethical considerations in qualitative study. *International Journal of Care* 1(2):30-35.

Arnesson, K & Albisson, G. 2017. Mentorship a pedagogical method for integration of theory and practice in higher education. *Nordic Journal of Studies in Educational Policy* 3(3):202:217.

Asiamah, N, Mensah, HK & Oteng-Abayie, E. 2017. General, target and accessible population: Demystifying the concepts for effective sampling. *The qualitative report* 22(6):1607-1621.

Athistham, Y & Jacoline, S. 2015. Integrating nursing theory and process into practice, Virginia's Henderson Need theory. *International Journal of Caring Sciences* 8(2):443-552.

Austin, Z. 2016. How to design and use learning objectives in clinical teaching. *The Pharmaceutical Journal* 296(7885):1-9

Australian Council for International Development. 2017. *Principles and Guidelines for ethical research and evaluation in development.* Australian Universities: ACTFID.

Baraz, S, Memarian, R & Vanaki, Z. 2015. Learning challenges of nursing students in clinical environments: A qualitative study in Iran. *Journal of Education Health Promotion*4:52.

Bah, TK. 2016. Clinical supervision in and mentorship in nursing. *International Journal of Innovative Research and Advanced Studies* 3(10):311-316.

Bashan,B & Holsblat, R. 2017. Reflective journals as a research tool: the case of student teachers' development of teamwork. *Cogent Education* 4:1-15

Baumgartner, R, Stahl, CH, Manninen, K & Hedman, AMR. 2017. Assessment of nursing students in clinical practice- an intervention study of a modified process. *Journal of Nursing Education and Practice* 7(11):111-122.

Baxley, SM, Ibitayo, K & Bond, ML. 2014. *Mentoring today's nurses: A global perspective for success*. Indianapolis: Sigma Theta Tau International.

Beers, GW & Berry, CG. 2015. Traditional versus electronic resources for students in clinical nursing courses: A pilot study. *Online Journal of Nursing Informatics* 19(1):1-6.

Benette, M & McGowan, B. 2014. Assessment matters - mentors need support in their role. *British Journal of Nursing* 23(9):454-457.

Benner, P. 1982. From novice to expert. *The American Journal of Nursing* 82(3):402-407.

Benner, P. 1984. *From Novice to Expert: Promoting Excellence and Power in Clinical Nursing Practice*. Menlo Park: Addison-Wesley.

Berk, RA, Berg, J, Mortimer, R, Walton-Moss, B & Yeo, T. 2005. Measuring the effectiveness of faculty mentoring relationship. *Journal of Academic Medicine* 80(1):60-71.

Berman, EA. 2017. An Exploratory sequential mixed methods approach to understanding researchers' data management practices at University of Vermont: integrated findings to develop research data services. *Journal of eScience Librarianship* 6(1):1104.

Blaauw, D, Ditlopo, P & Rispel, LC. 2015. *Transforming nursing education in South Africa; lessons from a policy analysis study.* Johannesburg: University of Witwatersrand.

Boddy, CR. 2016. Sample size for qualitative research. *International Journal of Qualitative Market Research* 19(4):426-432.

Bowel, K. 2018. *What constitutes an expert registered nurse in labour and delivery*. Unpublished thesis: Ontario: Brock University.

Bowling, A. 2014. *Research methods in health: investigating health and health services.* 4th edition. Berkshire: Open University Press.

Bowrey, S & Thompson, JP. 2014. Nursing research: ethics consent and good practice. *Nursing Standard* 1(3):20-23.

Brand, D. 2016. A focus on placement learning opportunities for student nurses-literature review. *Brighton Journal of Research in Health Sciences* 1(2):1-7.

Braun, V & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2):77-101.

Brynildsen, G, Bjork, IT, Bernsten, K & Hestetun, M. 2014. Improving the quality of nursing students' clinical placements in nursing homes: an evaluative study. *Nursing Education in Practice* 14:722-728.

Burden, SE. 2017. *Developing mentor skills in written feedback on student performance in practice settings: evaluation of a workshop*. RCN Education Forum International Conference: Cardiff.

Burgess, A & Mellis, C. 2015. Feedback and assessment for clinical placements: achieving the right balance. *Journal of Advances in Medical Education and Practices* 6:373-381.

Burma, ZA. 2015. Human resource management and its importance for today's organisations. *International Journal of Education and Social Science* 1(2):85-94.

Buthelezi, SF, Fakude, LP, Martin, PD & Daniels, FM. 2015. Clinical learning experience of male nursing students in a Bachelor of Nursing programme: strategies to overcome challenges. *Curatonis* 38:1-7.

Bvumbwe, T, Malema, A & Chipeta, M. 2015. Registered nurses' experiences with clinical teaching environment in Malawi. *Open Journal of Nursing*, 5:927-934.

Bvumbwe, T & Mtshali, N. 2018. Nursing education challenges and solutions in Sub Saharan Africa: an integrative review. *BMC Nursing* 17:1-11.

Cambridge Dictionary. 2018. *Framework*. From: http://dictionary. Cambridge. Org /dictionary / english / framework (Accessed on 18 June 2016).

Canadian Nurses Association. 2004. *Achieving excellence in professional practice: a guide to preceptorship and mentoring.* Ottawa: Author.

Caputi, LJ. 2017. Innovation in nursing education revisited. *National league for nursing* 38(3):112.

Carlson, K. 2015. *Is it time to find a nursing mentor?* From: http://www.nurse.com/blog/2015/12/21 (Accessed on 7 November 2016).

Central Statistical Office. 2008. *Statistics and indicators on Mauritius*. Port Louis: Government Printing.

Centre for Disease Control and Prevention. 2016. *Definition of Policy.* From: https://www.cdc.gov/policy/analysis/process/definition.html (Accessed on 10 September 2016).

Chan, C. 2002. Development of the clinical learning environment inventory: using the theoretical framework of learning environment studies to assess nursing students' perceptions of the hospital as a learning environment. *Journal of Nursing Education*41(2):69-75.

Chen, CM & Lou, MF. 2014. The effectiveness and application of mentorship programmes for recently registered nurses: a systematic review. *Journal of Nursing Management* 22(4):433-442.

Chen, Y, Watson, R & Hilton, A. 2016. A review of mentorship measurement tools. *Nurse Education Today* 40:20-28.

Chinn, P.L. & Kramer, M.K. 1995, *Theory and nursing: a systematic approach*, 4th edition. Mosby: St. Louis.

Choudary, V, Kumar, A & Kumari, V. 2014. Development of the clinical learning environment and supervision evaluation (CLESE). *International Journal of Nursing Science* 4(1):11-15

Clement, S. 2018. Concept analysis of virtual mentoring. *COJ Nurse Healthcare* 1(5):1-6.

Clement, SA & Welch, S. 2018. Virtual mentoring in nursing education. A scoping review of the literature. *Journal of Nursing Education and Practice* 8(3):137-143.

Colour Psychology. 2018. *Psychological Properties of Colours*. From: http// http://www.colour-affects.co.uk/psychological-properties-of-colours (Accessed on 18 October 2019).

Cope, DG. 2014. Methods and meanings: credibility and trustworthiness of qualitative research. *Oncology Nursing Forum* 41(1):89-91

Cresswell, JW & Cresswell, JD. 2018. *Research design, qualitative, quantitative and mixed methods approaches*. 5th edition. London: Sage Publication.

Cunningham, F, Baird, M & Wright, C. 2015. Managing clinical education through understanding key principles. *Journal of Radiologic Technology* 86(3):257-273.

De Abreu, WC & Interpeler, SS. 2015. Effective mentorship to improve clinical decision making and a positive identity: a comparative study in Turkey and Portugal. *International Journal of Information and Education Technology* 5(1):42-46.

De Brew, JK & Lewallen, LP. 2014. To pass or to fail? Understanding the factors considered by faculty in the clinical evaluation of nursing students. *Nurse Education Today* 34(4):631-636.

Denscombe, M. 2014. *The good research guide for small scale research projects.* 5th edition. Berkshire: Open University Press.

Dickoff, J, James, P & Wiedenbach, E. 1968. Theory in a Practice Discipline. *Nursing Research* 17(5):415-435.

Dimitriadou, M, Papastavarou, E, Efstathiou, G & Theodorou, M. 2015. Baccalaureate nursing students' perceptions of learning and supervision in the clinical learning environment. *Journal of Nursing and Health Sciences* 17:236-242.

Dinmohammadi, M, Peyrovi, H & Mehrdad, N. 2013. Concept analysis of professional socialization in nursing. *Nursing Forum* 48(1):26-34.

Direko, KK & Maselesele, MD. 2017. A model between nursing education institutions in the North West Province of South Africa. *Curationis* 40(1):1-10.

Dlama, GJ, Modupe, O & Umar, A. 2015. Perception of nursing students and clinical preceptors about the factors influencing clinical performance of nursing students. *Journal of Nursing and Health Sciences* 4(5):57-69.

Doorenbos, AZ. 2014. Mixed methods in nursing research: an overview and practical examples. *Kango Kenyu* 47(3):207-217.

Dorsey, LE & Baker, CM. 2004. Mentoring undergraduate nursing students: assessing the state of science. *Nursing Educator* 29(6):260-265.

Douglas, V, Garity, J, Shepherd, K & Brown, L. 2016. Nurses perceptions and experiences of mentoring. *Nursing Management* 23(1):34-37.

Drahosz, KW. 2015. *Seven steps to mentoring success*. From: http://www.thetrainingconnection.com/7-steps (Accessed on 3 March 2019).

Drateru, KC. 2019. Challenges experienced by student nurses during skills acquisition at the clinical area. *Journal of Nursing Primary Care* 3(3):1-4.

Duffy, K. 2015. Integrating 6C, s of nursing into mentorship practice. *Nursing Standards* 29(50):49-58.

Duffy, K & Gillies, A. 2018. Supervision and assessment: the new nursing and midwifery council standards. *Nursing Management* 25(3):17-21.

Durand, MA & Tracey, C. 2014. *Principles of social research*. 2nd edition. Berkshire: Open University.

Eller, LS, Lev, EL & Feurer, A. 2014. Key components of an effective mentoring relationship: a qualitative study. *Nurse Education Today* 34(5):82-89.

EL Hussein, MT & Osuji, J. 2017. Bridging the theory practice dichotomy in nursing: the role of nurse educators. *Journal of Nursing Education and Practice* 7(3):20-24.

Ereumegme, GO. 2015. Impact of business environment on organisation performance in Nigeria- A study of union bank of Nigeria. *European Scientific Journal* 7:478-493.

Ericksen, K.2017.*The importance of critical thinking skills in nursing*. https://www.rasmussen.edu/degrees/nursing/blog/understanding-why-nurses-need-critical-thinking-skills/ (Accessed on 3 April 2019).

Faithfull-Byrne, A, Thompson, L, Schafer, KW, Elks, M, Jaspers, J, Welch, A, Williamson, M, Cross, W & Moss, C. 2015. Clinical coaches in nursing and midwifery practice: facilitating point of care workplace learning and development. *The Australian Journal of Nursing Scholarship and Research* 24(4):403-410.

Farokhzadian, J, Khajouei, R & Ahmadian, L. 2015. Evaluating factors associated with implementing evidence-based practice in nursing. *Journal ofEvaluation in Clinical Practice* 21:1107-1113.

Fawaz, MA, Hamdan-Mansour, A & Tassi, A. 2018.Challenges facing nursing education in the healthcare environment. *Journal of Africa Nursing Sciences* 9:105-110.

Fetters, MD, Curry, LA & Cresswell, JW. 2013. Achieving integration in mixed methods, designs – Principles and practices. *Health Services Research* 48(6):1-22.

Field, WL. 1991. Mentoring in nursing: a historical approach. *Nursing Outlook* 39(6):257-61.

Flott, EA & Linden, L. 2016. The clinical learning environment in nursing education: a concept analysis. *Journal of Advanced Nursing* 72(3):501-513.

Foley, AS & Davis, AH. 2017. A guide to concept analysis. *Clinical Nurse Specialist: Journal of Advanced Nursing Practice* 31(2):70-73.

Foster, H, Ooms, A & Marks-Maran, D. 2015. Nursing students' expectation and experiences of mentorship. *Nursing Education Today* 35(1):18-24.

Fulton, J. 2015. The archeology and genealogy of mentorship in English nursing. *Nursing Inquiry* 22(1):257-261

Gallup, C. 2017. *Four steps to implement a mentoring system*. From: https://www.esoppartners.com/blog/ (Accessed on 3 February 2019).

Gangadharan, P, Al-Wahed, MAA & Ali Assiri, MM. 2016. Effectiveness of clinical teacher behaviours as perceived by nursing students graduates and faculty of King Khalid University, College of Applied Medical Science, Mohail Kingdom of Saudi Arabia. *International Journal of Current Advanced Research* 5(3):651-656.

Gentles, SJ, Charla, C, Ploeg, J & McKibbon, KA. 2015. Sampling in qualitative research-insights from an overview of the methods literature. *The qualitative report* 20(11):1172-1789.

Goldie, J, Dowie, A, Goldie, A, Cotton, P & Morrison, J. 2015. What makes a good clinical student and teacher? *BMC Medical Education* 15:32-40

Goodare, P. 2015. Literarure review: “Are you ok there?” The socialisation of students and graduates nurses: do we have it right?. *Australian Journal of Advanced Nursing* 33(1):38-43.

Grant, C & Osanloo, A. 2014. Understanding, selecting and integrating a theoretical framework in dissertation research: creating a blueprint for your “house”. *Administrative Issues Journal: Connecting Education, Practice and Research*10:12-26.

Greenfield, J. 2015. Mentorship at the heart of nursing education. *Practice Nurse* 45(3):27-29.

Greenway, K. 2014. Ritual in nursing: intramuscular injection. *Journal of Clinical Nursing* 24:3583-3588.

Green, J & Jackson, D. 2014. Mentoring: some cautionary notes for the nursing profession. *Contemporary Nurse* 47(1-2):79-87.

Grossman, S. 2013. *Mentoring in Nursing: A dynamic and collaborative process*. 2nd edition. New York: Springer Publishing Company.

Grove, SK, Gray, JR & Burns, N. 2015. *Understanding Nursing Research: Building Evidence Based Practice*. 6th edition. Missouri: Elsevier Saunders.

Grow, GO. 1991. Teaching learners to be self-directed. *Adult Education Quarterly* 41(3):125-149.

Guertterman, TC. 2015. Description of sampling practice within five approaches to qualitative research in education and the health sciences. *Qualitative Social Research* 16(2):1-24.

Gunay, U & Kilinc, G. 2018. The transfer of theoretical knowledge to clinical practice by nursing students and the difficulties they experience: A qualitative study. *Nursing Education Today* 65:81-86.

Gurbutt, DJ & Gurbutt, R. 2016. Reflection on a coaching pilot project in healthcare settings. *Journal of Higher Education Pedagogies* 1(1):89-94.

Ha, CM & Verishagen, N. 2015. *Applying Kolb's learning theory to library instruction: an observational study.* From: https://journals.library.ualberta.ca/eblip/index.php/EBLIP/article/view/24924/19321 (Accessed on 25 March 2015).

Habimana, A, Tuyizere, M & Uwajeneza, P. 2016. Clinical supervision of nursing students: challenges and alternatives. *Journal of Medical and Health Sciences* 3(1):42-43.

Hadi, MA. 2016. Ensuring rigour and trustworthiness of qualitative research in clinical pharmacy. *Journal of International Clinical Pharmacy* 38(3):641-646.

Hagg-Martinelle, A, Hult, H, Henrikson, P & Kiesseling, A. 2014. Students perceive healthcare as a valuable learning environment when accepted as a part of workplace community. *Education for Health* 27(1):15-23.

Halcomb, E. & Hickman, L. 2015. Mixed methods research. *Nursing Standard* 29(32):41- 47.

Hardavella, G, Aamli – Gaagnat, A, Saad, N, Rousalova, I & Sreter, KB. 2017. How to give and receive feedback effectively. *Breathe* 13:327-333.

Harding, T & Mawson, K. 2017. Richness and reciprocity undergraduate student nurse mentoring in mental nurse; mentoring in mental health. *Sage Open Learning* 3:1-9

Hardman, J. 2016. *Mentorship Policy/ The Implementation of the Nursing and Midwifery Council (NMC) Standards to Support Learning and Assessment in Practice*. Pennine Care: NHS Foundation Trust.

Harvey, S & Uren, CD. 2018. Collaborative learning application of the mentorship model for adult nursing students in acute placement setting. *Nursing Education Today* 7(4):38-40.

Heale, R & Twycross, A. 2015. Validity and Reliability in quantitative studies. *British Medical Journal* 18(3):66-67.

Heeralal, PJH. 2014. Student teachers perspective of qualities of good mentor teachers. *Anthropologist* 17(1):243-249.

Helminen, K, Tossovainen, K & Turunen, H. 2014. Assessing clinical practice of student nurses': views of teachers, mentors and students. *Nurse Education Today* 34:1161-1166.

Helminen, K, Coco, K, Johnson, M, Turunen, H & Tossovainen, K. 2016. Summative assessment of clinical practice of student nurses: a review of the literature. *International Journal of Nursing Studies* 53:308-319.

Hodgson, AK & Scalan, JM. 2013. A concept of analysis of mentoring in nursing leadership. *Open Journal of Nursing* (3):389-394.

Horner, DK. 2017. Mentoring positively, influencing job satisfaction and retention of new hired nurse practitioners. *Journal of Plastic Surgical Nursing* 37(1):7-32.

Houghton, CE. 2014. "Newcomer adaptation": a lens through which to understand how nursing students fit in with the real world of practice. *Journal of Clinical Nursing* 23:2367-2368.

Houghton, T. 2016. Developing mentors to support students in practice: creating an environment for learning. *Nursing Standard* 32(11):48-53.

Horner, DK. 2017. Mentoring positively, influencing job satisfaction and retention of new hired nurse practitioners. *Journal of Plastic Surgical Nursing* 37(1):7-32.

Hudson, P. 2016. Forming the mentor mentee relationship. *Journal of Mentoring and Tutoring: Partnership in Learning* 24(1):30-43.

Huggins, D. 2016. Enhancing nursing students' education by coaching mentors. *Nursing Management* 23(1):28-33.

Human Resource Development Council 2015. *Training needs analysis for health professionals*. Government Printing: Port Louis.

Hung, L. 2017. Critical reflection on practice development; using appreciative inquiry to research practical development. *International Practice Development Journal* 5(1):1-7.

Hutchinson, M & Jackson, D. 2015. Intentional rounding: unpacking the ritual, routine and evidence impasse. *Journal of Clinical Nursing* 1(25):5-7.

Imenda, S. 2014. Is there a conceptual difference between theoretical and conceptual frameworks? *Journal of Social Science* 38(2):185-195.

Ingham-Broomfield, R. 2015. A nurse's guide to quantitative research. *Australian Journal of Advanced Nursing* 32(2):32-38.

Ingham-Broomfield, R. 2016. A nurse's guide to qualitative research. *Australian Journal of Advanced Nursing* 33(4):46-52.

Irby, BJ & Boswell, J. 2016. Historical print context of the term mentoring. Journal of mentoring and tutoring. *Journal of Mentoring and Tutoring Partnership in Learning* 24(1):1-7.

Irvin, AV. 2014. *Policies and Procedures for healthcare organisation: a risk management perspective.* From: https://www.psqh.com/analysis/policies-and-procedures-for-healthcare-organizations-a-risk-management-perspective/ (Accessed 14 September 2018).

Jacobs, S. 2018. An analysis of the evolution of mentorship in nursing. *International Journal of Mentoring and Coaching in Education* 7(2):155-176.

Jacobsen, F & Hansen, J. 2014. Spreading the concept: an attempt to translate an interprofessional clinical placement across a Danish hospital. *Journal of interprofessional care* 28(5):407-412.

Jamshidi, N, Mozalem, Z, Sharif, F Torabizadeh, C & Kalyani, MN. 2016. The challenges of nursing students in the clinical learning environment: a qualitative study. *The Scientific World Journal* 10(1):1-7.

Javadi, M & Zarea, K .2016. Understanding thematic analysis and its pitfalls. *Journal of Client care* 1(1):34-40.

Jokelainen, M. 2013. *The elements of effective nurse mentorship in placement learning environment: systematic review and Finish and British mentors, conceptio*ns. University of Eastern Finland: Faculty of Health Sciences.

Joolea, S, Farahani, MA, Amiri, SRJ & Varoei, S. 2016. Support in clinical settings as perceived by nursing students in Iran: A qualitative study. *Journal of Nursing and Midwifery Student* 5(1):1-7.

Joubert, A & De Villiers, J. 2015.The learning experiences of mentees and mentors in a nursing school's mentoring programme. *Curationis* 38(1):1-7.

Keane, MB & Long, J. 2015. *Mentoring-in-post-graduate-medical-education and specialist training.* From:https://www.semanticscholar.org/paper/Mentoring-in-post-graduate-medical-education (Accessed on 6 September 2019).

King's College. 2013. *Policy plus evidence, issues and opinions in healthcare: should all nurses be mentors?* From: https://www.kcl.ac.uk/nursing/research/nnru/policy/By-Issue-Number/Policy--Issue-41-final.pdf (Accessed on 6 November 2016).

Kolb, DA.1984. *Experiential learning: Experience as the source of learning and development*. New Jersey: Prentice-Hall.

Koskei, B & Simiyu, C. 2015. Role of interviews, observation, pitfalls and ethical issues in qualitative research methods. *Journal of Educational Policy and Entrepreneurial research* 2(3):108-117.

Kourtney, B. 2016. Mentoring new nurses. *American Journal of Nursing* 116(10):13.

Knowles, M. 1973. *The adult learner: A neglected species*. Houston: Gulf Publishing.

Lakasing, E & Francis, H. 2005. The crisis in mentorship. *Journal of Primary Health Care* 15(4):40-41.

Lawal, J, Weaver, S, Bryan, V & Lindo, J. 2016. Factors that influence the clinical learning experience of nursing students at a Caribbean school of nursing. *Journal of Nursing Education and Practice* 6(4):32-39.

Leary, JC, Schainker, EG, Anna, J & Leyenaar, L. 2016. The unwritten rules of mentorship: facilitators and barriers to effective mentorship in paediatric hospitals medicine. *Journal of American Paediatricians* 6(4):219-225.

Leavy, P. 2017. Quantitative, qualitative, mixed methods, arts-based and community based, participatory research approaches. London: Guilford Press.

Lee, JJ, Clarke, CL & Carson, MN. 2018. Nursing students' learning dynamics and influencing factors in clinical contexts. *Nurse Education in Practice* 29:103-109.

Le Flore, JL & Thomas, PL. 2016. Educational changes to support advanced practice nursing education. *Journal of Perinatal and Neonatal Nursing* 30(3):187-190.

Letswalo, LO & Peu, MD. 2015. Perceptions of student nurses regarding accompaniment in the clinical environment in Gauteng Province, South Africa. *African Journal for Physical, HealthEducation, Recreation and Dance* 1(2):351-368.

Liu, Y, Avant, KA, Aungsuroch, Y, Zhang, XU & Jiang, P. 2014. Patient outcomes in the field of nursing:A concept analysis. *International Journal of Nursing Sciences*1:69-74.

Liljedahl, M, Boman, LE, Bjork, E & Laksov, KB. 2015. Participation in a clinical learning environment. *The Clinical Teacher* 12:284-285.

Luhanga, FL, Larocque, S, McEwan, L Gwekwerere, YN & Danyluk, P. 2014. Exploring the issue of failure to fail in professional education programs: a multi-disciplinary study. *Journal of University Teaching and Learning Practice* 11(20):1-20.

Mabuza, LH, Govendor, I, Ogunbanjo, GA & Mash, A. 2014. African primary care research: qualitative data analysis and writing results. *African Journal of Primary Healthcare Family Medicine* 6(1):1-5.

Mac Laren, JL. 2018. Supporting nurse mentor development: an exploration of developmental constellations in nursing mentorship practice. *Nursing Education in Practice* 28:66-75.

Maguire, M & Delahunt, B. 2017. Doing a thematic analysis: a practical step to step guide for teaching and learning scholars. *Ireland Journal of Teaching and learning in Higher Education* 3:1-14.

Mahajan, M & Sarjitsingh, MK. 2017. Importance and benefits of learning outcomes. *Journal of Humanities and Social Sciences* 22(3):65-67.

Manerikar, V & Manerikar, S. 2014. A note on exploratory research. *Research Communication* 17(1):95-97.

Mannino, J & Cotter, R. 2016. Educating nursing students for practice in the 21st century. *International Archives of Nursing and Health Care* 2(1):1-5.

Manister, NE & Frederickson, KV. 2016. *Developing faculty student mentor relationship in a DNP programme: 43rd biennial convention*. Las Vegas: Sigma Theta Tau International.

Matin, AS. 2017. Understanding effective mentoring in nursing education: the relational reliant concept. *JOJ Nursing Health C*are 2(5):1-3.

Maxwell, E, Sharon, B & Baillie, L. 2015. The role of the practice educator in supporting nursing and midwifery students' clinical practice learning: *An appreciative inquiry. Journal of Nursing Education and Practice* 5(1):35-45.

McCloughen, A, O'Brien, L & Jackson, D. 2014. Journey to become a nurse leader mentor past, present and future influences. *Nursing Inquiry* 21(4):301-310.

McCusker, K & Gunaydin, S. 2015. Research using qualitative or mixed methods and choice based on the research. *Perfusion* 30(7):537-542.

McEwen, M & Willis, M. 2014. *Theoretical basis for nursing*. 4th edition. Lippincott: New York.

McInerney, PA & Green- Thompson, LP. 2018. Teaching and learning theories and teaching methods used in post graduate education in health sciences. *JBI Database of systematic reviews Implementation Reports* 15(4):899-904.

McMillan Dictionary. 2018. *Definition of skill.* From: https://www.macmillandictionary.com/ (Accessed on 2 November 2018).

McMahon, T. 2016. *What mentoring*? From: http://www.aleanjourney.com/2016/06/mentoring-origin-and-meaning.html (Accessed on 3rd September 2019).

Mercia, CJ. 2016. *What influences industry to offer clinical placements for pre registration nursing students*. Unpublished thesis: University of Wollongong.

Mgbekem, MA, Ojong, IN, Lukpata, FE, Armon, M & Kalu, V. 2016. Middle range theory evaluation. Bridging the theory-practice gap. *Global Journal of Pure and Applied Sciences* 22:249-254.

Mijares, L, Baxley, SM & Bond, ML. 2013. Mentoring: a concept analysis. *Journal of Theory Construction and Testing*, 17(1):23-28.

Miller, GE. 1990. The assessment of clinical skills/competence/performance. *Academic Medicine* 65(9):63-67.

Miller, J, Vivona, B & Roth, G. 2016. Nursing preceptors and meaning making. *The Qualitative Report* 21(11):2014-2032.

Ministry of Health and Quality of life. 2016. *Health statistics annual*. Port-Louis: Government Printing.

Ministry of Health and Quality of life. 2018. *Health statistics annual*. Port-Louis: Government Printing.

Mohammadi, I & Thaghinejad, H. 2014. Learning styles of nursing students in Iran using Kolb's theory: a review theory. *Journal of Basic Research and Medical Sciences* 1(1):8-14.

Mokgele, EL & Caka, EM. 2015. Facilitative and obstructive factors in the clinical learning environment: experiences of pupil enrolled nurses. *Curatonis* 38(1):1263-1270.

Motsilanyane, PT. 2015. *Exploring the clinical accompaniment challenges of second year students experience at a nursing education institution in North West*. Unpublished Thesis: University of Pretoria.

Moxham, L & Gagan, A. 2015. Clinical supervision as a means of professional development in nursing. *Australian Journal of Nursing and Midwifery 23*(2):37.

Mubeezi, MP & Gidman, J. 2017. Mentoring student nurses in Uganda: A phenomenological study of mentors' perceptions of their own Knowledge and skills. *Nurse Education Today* 26:96-101.

Muleya, CM, Marshall, J & Ashwin, C. 2015. Nursing and midwifery students' perception and experiences of mentorship: a systematic review. *Open Journal of Nursing* 5:571-586.

Murray, R. 2018. An overview of experiential learning in nursing education. *Advances in Social Sciences Research Journal* 5(1):1-6.

Muthati, S, Thurling, CH & Armstrong, SJ. 2017. Through the eyes of the students: Best practices in clinical facilitation. *Curatonis* 40(1):1-8.

Mwale, OG & Kalawa, R. 2016. Factors affecting the acquisition of psychomotor clinical skills by nurses and midwives in CHAM nursing colleges in Malawi: a qualitative exploratory study. *Bio Medical Central Nursing* 15(1):1-9.

Nangombe, JP & Amukugo, HJ. 2016. Development of the conceptual framework for a quality improvement training programme for health professionals in the ministry of health and social services in Namibia. *International Journal of Health* 4(1):46-53.

Narang, S. 2018. *Nursing- the backbone of healthcare delivery in the quest for universal access*. From: https://www.asianhhm.com/articles/nursing-the-backbone-of-healthcare-delivery. (Accessed 8 November 2019).

Nasri, MN. 2017. Self-directed learning through the eyes of teacher educators. *Kasetstart Journal of Social Sciences* 6:1-8.

National Health England 2016. *Leading Change, Adding Value. A framework for nursing, midwifery and care staff*. From: www.england.nhs.uk/wp-content uploads/2016/05/nursing-framework.pdf (Accessed 11 April 2017).

Ndempavali, S & Amakugo, HJ. 2016. A conceptual framework as basis for the development of a psychosocial educational programme to facilitate the reintegration of incarcerated women who had dumped babies and/or committed infanticide. *International Journal of Health* 4(2):102-111.

Neupane, N, Pandey, N & Sah, SK. 2018. Perception of clinical learning environment among nursing students. *International Journal of Microbiology and Health Research* 2(1):36-41.

Nghipondoka-Lukolo, LN & Charles, KL. 2016. Parents' participation in the sexuality education of their children in Namibia: a framework for educational programme for enhanced action.

NHS Education for Scotland. 2013. *National Approach to mentor preparation for nurses and midwives.* From: https://www.nes.scot.nhs.uk/media/2071831/national-approach-to-mentor-preparation-2nd-edition.pdf(Accessed 25 October 2019).

Nielsen, K, Norlyk, A & Henriksen, J. 2019 Nursing students, learning experiences in clinical placements or simulation- A qualitative study. *Journal of Nursing Education and Practice.* 9(1):32-43.

Norman, K. 2015. How mentors can influence the values, behaviours and attitudes of nursing staff through positive professional socialisation. *Nursing Management* 22(8):33-38.

Nowell, L, White, D, Benzies, K & Roseneau, P. 2017. Factors that impact implementation of mentorship programs in nursing academia: A sequential-explanatory mixed methods study. *Journal of Nursing Education and Practice* 7(10):1-10.

Nowell, LS, Noris, JM, White, DE & Moules, NJ. 2017. Thematic analysis: striving to meet trustworthiness criteria. *International Journal of Qualitative methods* 16:1-3.

Nursing Council of Mauritius. 2003. *The nursing council act no 47 of 2003*. Port Louis: Government Printing.

Nursing and Midwifery Council. 2008. *Standard to support learning and assessment in practice*. London: Portland Palace.

Nursing and Midwifery Council. 2010. *Standards for pre-registration nursing education*. London: Portland Palace.

Nursing and Midwifery Council of New South Wales Australia 2011. *Mentoring Guideline.*From:https://www.nursingandmidwiferycouncil.nsw.gov.au/sites/default/files/nursing_and_midwifery_council_mentoring_guidelines_april_2011_1.pdf (Accessed on 23 September 2016).

Ojakaa, D, Olango, S & Jarvis, J. 2014. Factors affecting motivation and retention of primary healthcare workers in three disparate areas in Kenya. *Human Resources for Health* 12(33):1-13.

Olaolorunpo, O. 2019. Mentoring in nursing: a concept analysis. *International Journal of caring sciences* 12(1):142-148.

Oluchina, S & Amayi, J. 2016. Mentee's experiences in formal and informal mentorship programs in Kenya public universities. *Journal of Agriculture Science and Technology* 17(1):161-179.

Oluchina, S & Gitonga, LK. 2016. Factors Hindering Formal and Informal Nursing Mentorship Programs in Kenyan Public Universities. *American Journal of Health Research* 4(2):23-29.

Oshvandi, K, Moghadam, AS, Khatiban, M, Cheraghi, F, Borzu, R & Moradi, Y. 2016. On the application of the novice to expert theory in nursing; a systematic review. *Journal of Chemical and Pharmaceutical Sciences* 9(4):3014-3020.

Oxford Online Dictionary. 2018. *Clinical*.From:https://en.oxforddictionaries.com/definition/clinical (Accessed on 21 July 2018).

Papastavrou, E, Dimitriadou, M, Tsangari, H & Andreou, C. 2016. Nursing Students' satisfaction of the clinical learning environment: a research study. *BMC Nursing* 15:44.

Peake, C & Kelly, M. 2016. Views of mental health nurses on mentoring. *Nursing Times* 41(42):16-19.

Peiser, G, Ambrose, J, Burke, B & Devenport, J. 2018. The role of the mentor in professional development across four professions. *Journal of Mentoring and Coaching in Education* 7(1):2-18.

Peters, K, McInnes, S & Halcomb, E. 2015. Nursing students' experiences of clinical placement on community settings: a qualitative study. *The Australian Journal of Nursing Practice, Scholarship and Research* 22(2):175-181.

Phillips, AB & Merill, JA. 2015. Innovative use of integrative review to evaluate evidence of technology transformation in healthcare. *Journal of Biomedical Informatics* 58:114-121.

Phuma-Ngaiyaye, E, Bvumbwe, T & Chipeta, MC. 2017. Using preceptors to improve nursing students' clinical learning outcomes: A Malawian students' perspective. *International Journal of Nursing Sciences* 4:164-168.

Pishgooie, AH, Rahimi, A & Khaghanizadeh, M. 2014. The effect of role conflict on nursing faculty; a systematic review. *The International Journal of Medical Reviews* 1(2):69-74.

Pluye, P, Bengoechea, EG, Granikov, V, Kaur, N & Li Tang, D. 2018. A World of possibilities in mixed methods: Review of the combinations of strategies used to integrate qualitative and quantitative phases, results and data. *International Journal of Multiple Research Approaches* 10(1):41-46.

Potter, DR & Tolson, D. 2014. A mentoring guide for nursing faculty in higher education. *International Journal of Caring Sciences* 7(3):727-732.

Rafiee, G, Moattari, M, Nikbakht, AN, Kojuri, J & Mousavinasab, M. 2014. Problems and challenges of nursing students' clinical evaluation: a qualitative study. *Journal of Nursing and Midwifery Research* 19(1):41-49.

Rahi, S. 2017. Research designs and methods: a systematic review of research paradigms, sampling issues and instruments development. *International Journal of Economics and Management Sciences* 6(2):2.

Rahman, S. 2017. The advantages and disadvantages of using qualitative and quantitative approaches and methods in language “testing and assessment” research: a literature review. *Journal of Education and Learning* 6(1):102-112.

Rajeswaran, L. 2016. Clinical experiences of nursing students at a selected institute of health sciences in Botswana. *Journal of Health Science* 10(6):471-476.

Rakhudu, MA, Maselesele, MD & Useh, U. 2016. Concept analysis of collaboration for the implementation of a problem based learning. *Curationis* 39(1):1-13.

Risjord, M. 2018.Middle range theories as models: new criteria for analysis and evaluation. *Nursing Philosophy* 20:1-10.

Rohatinsky, N, Harding, K & Carriere, T. 2017. Nursing student peer mentorship: a review of literature. *Journal of Mentoring and Tutoring* 25(1):61-77.

Rowe, F. 2014. What literature review is not: diversity boundaries and recommendations. *European Journal of Information System* 23:241-255.

Royal College of Nursing. 2015. *RCN mentorship project 2015: From today’s support in practice to tomorrow’s vision for excellence*. London: RCN publishing.

Royal College of Nursing 2017. *Helping students to get the best from the practice placement*. London: RCN publishing.

Royal College of Nursing 2017. *RCN guidance for mentors of nursing and midwifery*. London: RCN publishing.

Ryan, C & McAllister 2019. The experiences of clinical facilitators working with nursing students in Australia; an interpretive description. *Science Direct* 26:281-287.

Rylance, R, Barett, J, Sixsmith, P & Ward, D. 2017. Student nurse mentoring: an evaluative study of the mentors' perspective. *British Journal of Nursing* 26(7):405-409

Sabog, RFV, Caranto, LC & David, JJT. 2015. Effective characteristics of a clinical instructor as perceived by BSU student nurses. *International Journal of Nursing* Science 5(1):5-19.

Saifan, A, Aburuz, ME & Masa'deh. 2015. Theory practice gap in nursing education: a qualitative perspective. *Journal of Social Science* 11(1):20-29.

Saleh, US. 2018. Theory guided practice in nursing. *Journal of Nursing Research Practice* 2(1):18.

Sambunjak, D. 2015. Understanding wider environmental influences on mentoring: Towards an ecological model of mentoring in academic medicine.*Journal of Academy Sciences and Arts* 44(1):45-47.

Sand, JN, Elison-Bowsers, P, Wing, TJ & Kendrick, L. 2015. Experiential learning and clinical education. *Academic Exchange Quarterly* 18(4):1-7.

Schuler, PD. 2017. *My journey of mentorship*. From: https://www.reflectionsonnursingleadership.org/features/more-features/My-journey-of-mentorship. (Accessed 26 October).

Shannon-Baker, P. 2016. Making paradigms meaningful in mixed methods research. *Journal of mixed methods Research* 10(4):319-334.

Seekoe, E. 2014. A model for mentoring newly appointed nurse educators in nursing education institutions in South Africa. *Curatonis* 37(1):132-140.

Setati, CM & Nkosi, ZZ. 2017. The perception of professional nurses on student mentorship in clinical areas: A study in Polokwane municipality hospitals, Limpopo province. *Health South Africa Gesondheid* 22:130-137.

Shaikh, AM. 2017. Understanding effective mentoring in nursing education: the relational – reliant concept. *JOJ Nurse Health Care* 2(5):1-3.

Shannon-Baker, P. 2016. Making paradigms meaningful in mixed methods research. *Journal of mixed methods Research* 10(4):319-334.

Shepherd, P & Uren, C. 2014. Protecting student's supernumerary status. *Nursing Times* 110(20):18-20.

Simelane-Mnisi, S & Mji, A. 2015. Establishing the reliability and validity of the Kolb learning. *International Journal of Education and Science* 11(3):312-319.

Sinnerton, T, Leonard, L & Rogers, KMA. 2015. Using learning style preferences to enhance the education and training of allied health professionals. *The Internet Journal of Health Sciences and practices* 12(1):1-5.

Solvik, E & Strukness, S. 2018. Training nursing skills: A qualitative study of nursing students' experience before and after clinical practice. *Nursing Practice* 10:1-9.

South African Nursing Council. 1992.*The philosophy and policy of the South African Nursing Council with regard to professional nursing education.* Pretoria: SANC

Spurr, S, Bally, J & Ferguson, L. 2010. A framework for clinical teaching: a passion centered philosophy. *Nurse Education in Practice* 10:349-354.

Stenberg, M & Carlson, E. 2015. Swedish student nurses' perception of peer learning as an educational model during clinical practice in a hospital setting – an evaluation study. *BMC Nursing* 14:48-55.

Stephen, M. 2015. Changing student nurses values, attitudes and behaviours. A meta ethnography of enrichment activities. *Journal of Nursing Care* 5:320-329.

Stewart-Lord, A, Baillie, L & Woods, S. 2017. Healthcare staff perceptions of a coaching and mentoring programme: a qualitative case study evaluation. *International Journal of Evidenced-Based Coaching and Mentoring* 15(2):70-85.

Strauss, LS, Johnson, MO, Marquez, C & Feldman, MD. 2013. Characteristics of successful and failed mentoring: a qualitative study across two academic health centers. *Journal of Academic Medecine* 88(1):82-89.

Suffin, M & O'Mahoney, H. 2014. A new role to improve mentorship standards. *Nursing Times* 110(45):15-17.

Tengah, A. 2016. Nursing students' perception on the benefits of a mentoring programme. *International Journal of Evidence base Healthcare* 14:37-38.

Thomas, CM & Kellgren, M. 2017. Benner's Novice to expert model:An application for simulation facilitators. *Nursing Science Quarterly* 30(3):227-234.

Thompson, CJ. 2016. *What does "clinical expertise" mean in evidenced based practice*? From: https://nursingeducationexpert.com/what-does-clinical-expertise-mean-ebp/ (Accessed 26 November 2016).

Tiwaken, SU, Caranto, LC & David, JJT. 2015. The real world - lived experiences of of student nurses during clinical practice. *International Journal of Nursing Sciences* 5(2):66-75.

Tomietto, M, Comparcini, D, Saarikoski, M, Simonetti, V & Cicolini, G. 2014. Multilevel perspective in clinical learning environments' assessment: an insight on levels involved in planning nursing education. *Journal of Nursing Education and Practice* 4(12):43-50.

Trajkovski, S, Schmied, V, Vickers, M & Hestetun, M. 2013. Using appreciative inquiry to transform healthcare. *Contemporary Nurse Journal of Australian Nursing Profession* 45(1):95-100.

Traynor, M & Mehigan, S. 2015. *What do we know about the implementation of and effectiveness of the Key/super mentor role? A literature review*. HENCEL report Middlesex University: UK.

Trees, L. 2017. *Six steps to mentoring program success.* From: https://www.td.org/insights/6-steps-to-mentoring-program-success (accessed on 3 March 2019).

Tuomikoski, AM & Kaariainen, M. 2016. Nurses' perceptions of their competence n mentoring nursing students in clinical practice: a systematic review of protocol of qualitative evidence. *JBI Database of Systematic Reviews and Implementation Reports* 14(7):98-107.

Tuomikoski, AM, Ruotsalainen, H, Mikkonen, K, Miettunen, J & Kaariainen, M. 2018. The competence of nurse mentors in mentoring students in clinical practice - A cross-sectional study. *Nursing Education Today* 71:78-83.

Vance, C. 2014. Mentorship in nursing: an interview with Connie Vance. *Nursing Economics* 32(2):65-69.

Venant, K. 2018. Nurse mentorship: two way street. *American Nurses Today* 13(10):1-4.

Vinales, JJ. 2015. The mentor as a role model and the importance of belongingness. *British Journal of Nursing* 24(10):532-535.

Vinales, JJ. 2016. Mentorship part 1: the role in the learning environment. *British Journal of Nursing* 24(1):50-53.

Wahab, TW, Iqbal, MFBM, Wu, JT, Westley, LTW, Kanesvaran, R & Krishna, LKR. 2016. Creating effective inter-professional mentoring relationships in palliative care lessons from medicine, nursing, surgery and social work. *Journal of Palliative care and Medicine* 6(6):1-10.

Walker, LO & Avant, KC. 2011. *Strategies for theory construction in nursing.* 5th edition. New York: Prentice Hill.

Walker-Reed, GA. 2016. Clinical coaching: the means to achieving a legacy of leadership and professional development in nursing practice. *Journal of Nursing Education and Practice* 6(6):41-47.

Walsh, K. 2015. Online mentoring in medical education. *South African Family Practice* (1):57-58.

Warburton, T, Houghton, T & Barry, D. 2016. Facilitating of learning: part 2. *Nursing Standards* 30(35):41-48.

Waweru, L, Mapesa, OJ & Elijah, N. 2016. Factors hindering integration of theory into practice by Bachelor of Science in nursing Thika level five hospital Kenya. *International Journal of Nursing Education* 8(4):99-104.

Whittmore, R & Knaft, K. 2005. The integrative review: updated methodology. *Journal of Advanced Nursing* 52(5):546-543.

William, M. 2018. *Four essentials mentoring skills*. From: https://www.mtdtraining.com/blog/4-essential-mentoring-skills.htm(Accessed 26 November 2018).

Willis Commission. 2012. *Report on Nurse Education Quality with compassion; the future of nursing education.*London: RCN publishing.

Witry, MJ, Nguyen, E & Patterson, BJ. 2015. Faculty mentor perspectives of a formal mentoring programme for students' pharmacists: a qualitative study. *Innovation Pharmacy* 6(4):1-9.

Xu, JH. 2016. Toolbox of teaching strategies in nursing education. Journal of Chinese *Nursing Research* 3:54-57.

Zakaria, AB & Rahman-Gheith, NA. 2015. Measurement of effectiveness of clinical learning environment for nursing faculty students at Mansourah University Egypt. *Journal of Nursing and Health Science* 4(3):35-45.

Zenani, NE. 2016. *Challenges experienced by second year nursing students when integrating theory into practice in a selected clinical setting in the Western Cape province*. Western Cape University: Unpublished Thesis.

Zhang, Y, Qian, Y, Wu, J, Wen, F & Zhang, Y. 2014. The effectiveness and implementation of mentoring programme for newly graduated nurses: a systematic review. *Nursing Education Today* 37:136-144.

Zohrabi, M. 2014. Mixed methods research: Instruments, validity, reliability and reporting finding. *Theory and practice in language studies* 3(2):254-262.

ANNEXURE A: Letter of Ethical Clearance from the University of South Africa

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

5 October 2016

HSHDC/539/2016
Mr Dhunraj Foolchand
Student: 3676-336-5

Supervisor: Prof JE Maritz
Qualification: PhD
Joint Supervisor: -

Dear Mr Dhunraj Foolchand

Decision: Ethics Approval

Name: Mr Dhunraj Foolchand

Proposal: Guidelines for effective mentoring in Mauritius: a nursing perspective.

Qualification: DPCHS04

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 5 October 2016.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Open Rubric

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

for Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

1 August 2018

Dear Mr D Foolchand

Decision: Ethics Approval

HSHDC/539/2016

Student: D Foolchand

Student No.:3676-336-5
Supervisor: Prof JE Maritz
Qualification DCur
Joint Supervisor: -

Name: D Foolchand

Proposal: A clinical mentoring framework for student nurses in Mauritius

Qualification: **DPCHS04**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 1 August 2018 to 1 August 2023

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on. 1 August 2018

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

RECEIVED
2018 -08- 03
Executive Dean
College of Human Sciences

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *You are required to submit an annual report by 30 January of each year that that he study is active. Reports should be submitted to the administrator HSREC@unisa.ac..az Should the reports not be forthcoming the ethical permission might be revoked until such time as the reports are presented.*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof A Phillips
DEAN OF COLLEGE OF HUMAN SCIENCES

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ANNEXURE B: Letter of Ethical Clearance from the Ministry of Health and Quality of Life

Ministry of Health and Quality of Life
Mauritius

The National Ethics Committee

Decision

The National Ethics Committee Meeting held on 28 March 2017 has

Awarded Ethical Clearance

to the above project proposal.

You are also requested to:-

(a) submit a Progress Report every month;
(b) notify the ethical Committee of any amendment of recruitment of material or of consent form, or of information to be submitted to the research participants;
(c) report to the Ethical Committee any serious or unexpected, unforeseen circumstances;
(d) report to the Ethical Committee termination of the project;
(e) provide relevant information to the Ethical Committee for ongoing review;
(f) give a copy of the Final Summary on the Final report to the Ethical Committee;
(g) ensure that confidentiality is expected throughout the project; and
(h) ensure that the question on ethic group is optional.

Dr (Mrs) M. Timol
for Senior Chief Executive

ANNEXURE C: Letter of permission

DR. V. DINASSING
Regional Health Director
Ministry of Health & QoL

From: Dhunraj FOOLCHAND

Charge Nurse, SSRN Hospital

The : Regional Health Director

Through: Regional Nursing Administrator

Flacq Hospital

Date: .....

Sir/ Madam,

Ref: Permission for data collection

I wish to inform you that I am a Doctoral student at the University of South Africa. I am currently undertaking a study for the completion of my degree PhD in nursing. The title of my study is "Guidelines for effective mentoring in Mauritius: a nursing perspective".

Please note that this study has obtained clearance from the Ethic Committee; Department of Health Studies, the University of South Africa (see attached copies). Data will be collected from both student nurses and nursing officers. Under no circumstances, this exercise will hamper the smooth running of the service. Clearance for the conduct of the study from the National Ethic Committee is subject to your approval.

In this respect, I humbly request for permission to proceed for data collection and your approval.

I trust and rely on your kind understanding.

Yours faithfully

Dhunraj FOOLCHAND

From: Dhunraj FOOLCHAND

Charge Nurse, SSRN Hospital

The : Regional Health Director

Through: Regional Nursing Administrator

Jawaharlal Nehru Hospital

Date: 27/1/2017

Dr. Ramsamy
SLS RNE
INE.

No objection

Ramsamy 27/1/2017

Sir/ Madam,

Ref: Permission for data collection

I wish to inform you that I am a Doctoral student at the University of South Africa. I am currently undertaking a study for the completion of my degree PhD in nursing. The title of my study is "Guidelines for effective mentoring in Mauritius: a nursing perspective".

Please note that this study has obtained clearance from the Ethic Committee; Department of Health Studies, the University of South Africa (see attached copies). Data will be collected from both student nurses and nursing officers. Under no circumstances, this exercise will hamper the smooth running of the service. Clearance for the conduct of the study from the National Ethic Committee is subject to your approval.

In this respect, I humbly request for permission to proceed for data collection and your approval.

I trust and rely on your kind understanding.

Yours faithfully

Dhunraj FOOLCHAND

From: Dhunraj FOOLCHAND

Charge Nurse, SSRN Hospital

The : Regional Health Director

Through: Regional Nursing Administrator

Jeetoo Hospital

Date: 27/01/2017

NP objection provided confidentiality is maintained + Ethical clearance from MOH in accordance with prevailing Act 27/01/17

REGIONAL NURSING ADMINISTRATOR M.O.H Dr. A.G. Jeetoo Hospital 27/01/17

Sir/ Madam,

Ref: Permission for data collection

I wish to inform you that I am a Doctoral student at the University of South Africa. I am currently undertaking a study for the completion of my degree PhD in nursing. The title of my study is "Guidelines for effective mentoring in Mauritius: a nursing perspective".

Please note that this study has obtained clearance from the Ethic Committee; Department of Health Studies, the University of South Africa (see attached copies). Data will be collected from both student nurses and nursing officers. Under no circumstances, this exercise will hamper the smooth running of the service. Clearance for the conduct of the study from the National Ethic Committee is subject to your approval.

In this respect, I humbly request for permission to proceed for data collection and your approval.

I trust and rely on your kind understanding.

Yours faithfully

Dhunraj FOOLCHAND

From: Dhunraj FOOLCHAND

Charge Nurse, SSRN Hospital

The : Regional Health Director 2/2/17

Dr B. ORI
Regional Health Director
Victoria Hospital

Through: Regional Nursing Administrator 3/2/17

Sir Sowmyadyal Ramgoolam Victoria Hospital

Date: .....

Sir/ Madam,

Ref: Permission for data collection

I wish to inform you that I am a Doctoral student at the University of South Africa. I am currently undertaking a study for the completion of my degree PhD in nursing. The title of my study is "Guidelines for effective mentoring in Mauritius: a nursing perspective".

Please note that this study has obtained clearance from the Ethic Committee; Department of Health Studies, the University of South Africa (see attached copies). Data will be collected from both student nurses and nursing officers. Under no circumstances, this exercise will hamper the smooth running of the service. Clearance for the conduct of the study from the National Ethic Committee is subject to your approval.

I am therefore requesting your kind approval.

I trust and rely on your kind understanding.

Yours faithfully

Dhunraj FOOLCHAND

ANNEXURE G

From: Dhunraj FOOLCHAND

Charge Nurse, SSRN Hospital

The : Regional Health Director

Through: Regional Nursing Administrator

Sir Seewoosagur Ramgoolam National Hospital

Date: 23.1.17

SSRN HOSPITAL
M. O. H.
Regional Nursing
Administrator
Date: 23.01.17

Sir/ Madam,

Ref: Permission for data collection

I wish to inform you that I am a Doctoral student at the University of South Africa. I am currently undertaking a study for the completion of my degree PhD in nursing. The title of my study is "Guidelines for effective mentoring in Mauritius: a nursing perspective".

Please note that this study has obtained clearance from the Ethic Committee; Department of Health Studies, the University of South Africa (see attached copies). Data will be collected from both student nurses and nursing officers. Under no circumstances, this exercise will hamper the smooth running of the service. Clearance for the conduct of the study from the National Ethic Committee is subject to your approval.

In this respect, I humbly request for permission to proceed for data collection and your approval.

I trust and rely on your kind understanding.

Yours faithfully

Dhunraj FOOLCHAND

ANNEXURE D: Information and consent form for participants

INFORMATION SHEET /CONSENT FORM

STUDY TITLE: Guidelines for effective mentoring in Mauritius: a nursing perspective

INVESTIGATOR: Mr. D Foolchand e-mail:dfoolchand@yahoo.com

Dear Participant,

I am DhunrajFOOLCHANDthe principal researcher for the study on “A conceptual framework for clinical mentoring of student nurses in Mauritius”. I am a registered nurse and a doctoral student of the University of South Africa. You are hereby invited to participate in the above mentioned study.

The aim of the study is to develop guidelines effective mentoring for nurses in order to enhance the standards of student nurses’ training in clinical placements. The study involves the collecting of information from qualified nurses and third year student nurses in two phases. The first phase will involve the collection of data from qualified nurses only through face to face interview and the second phase will focus on the collection of data from both nurses and student nurses through a self administered questionnaire. Although this study may not benefit you directly, it will help to have a better insight on how mentoring is practiced in the local context. An appointment will be made with you at a time which is most convenient. This might take approximately45 minutes to one hour. Your participation in this study is voluntary and you are under no obligation to participate. You can withdraw at any time without penalty. You will not receive any reimbursement. The data collected will be kept confidential and anonymous. Your name will not be revealed while the study is conducted or in the event it is published or reported. All information will be under my safe keeping and will be stored in a safe place and shared only among those involved in the study. The data will be destroyed after the completion of the study. You may request a report of the findings.

You are free to contact me on 418-3485 (Home) or 5910-3335 if you have further questions.

Should you have concerns about the way in which the research has been conducted, you may contact Professor L Roets, Ethics Chair of the Department of Health Studies at roetsl@unisa.ac.za.

Thank you in advance for your participation.

I have read this information and voluntarily consent to participate in the study and also agree to be tape recorded.

_____ _____

Participant Signature Date

I have explained this study to the above participant and have sought his/her understanding.

_____ _____

Investigator Signature Date

ANNEXURE E: Interview guide

INTERVIEW GUIDE

1. Tell me about your experience as a mentor?

2. What, if any, are the constraints that impact on your role as a mentor?

3. Describe how mentoring contributes to the professional growth of students'in their preparation for fitness to practice?

4. What should a conducive clinical learning environment consist of with regards to mentoring?

5. According to you what qualities should a good mentor have?

6. What could be done to improve mentoring in the clinical environment?

PROBES

1. Describe your experience?

2. Could you please elaborate further?

4. Tell me more?

ANNEXURE F: Questionnaire for students

Questionnaire number _____

QUESTIONNAIRE IN MENTORING FOR STUDENT NURSES

STUDY TITLE: A conceptual framework for clinical mentoring of student nurses in Mauritius.

Dear Participant,

Please complete all questions on this form. This will take approximately 30 - 40 minutes. Tick or circle your answer accordingly.

Dhunraj FOOLCHAND

University of South Africa

Mentoring is the process where a more experienced individual uses his/her greater knowledge, skills,
experience and understanding to support the development of a junior or less experienced individual.

Mentorrefers to the more experienced nurse in the mentoring relationship. The term mentor in this questionnaire refers to qualified experienced nurses and **mentee** to third year students.

SECTION A - BACKGROUND INFORMATION

1. Please state your gender -

Male	1
Female	2

2. Your age group -

20 - 25 years	1
26- 31 years	2
31- 35 years	3

3. Your secondary level of Education

School Certificate/GCE	1
Highest School Certificate/ GCE “A” Level	2

4. Post secondary qualifications: (*specify if any)*……

5. Practical placements completed:

Medical	1	Intensive Care Unit	7
Surgical	2	Neurosurgery	8
Orthopedics	3	Pediatrics	9
Obstetrics&Gynecology	4	Dialysis	10
Cardiac	5	Psychiatry	11
Accident &Emergency	6	ENT, Burn, Ophthalmology& Oncology units,PublicHealth,Community,Psychiatry	12

SECTION B- CURRENT PRACTICE OF MENTORING

6. Is there a mentoring system in the ward to support students learning?

Yes	1
No	2
Uncertain	3

7. Have often have you been mentored throughout your practice placements?

Frequently	1
Occasionally	2
Sometimes	3
Rarely	4

8. Do you consider the current mentoring system to be

Formal Mentoring	1
Informal Mentoring	2
Both formal and informal Mentoring	3
Uncertain	4

9. Are you and your colleagues involved in peer mentoring at times?

Often	1
Occasionally	2
Sometime	3
Rarely	4
Never	5

10. How frequent do Nurse Educators from school visit students during their clinical placements?

Often	1
Occasionally	2
Sometime	3
Rarely	4
Never	5

11. Taking into consideration the various constraints of the clinical learning environment, what would be the ideal ratio of mentor to students'?

1:1	1
1:5	2
1:10	3
1:15	4

12. To what extent does the actual mentoring system meet your learning needs?

To a great extent	1
To a little extent	2
Uncertain	3
To a very low extent	4

13.Are you of the view that all qualified nurses should act as mentors

Yes	1
No	2
Uncertain	3
May be	4

14.Are you of the opinion that mentor should be considered as a separate career pathway?

Yes	1
No	2
Uncertain	3
May be	4

15. Does mentoring help in shaping your professional development and self-confidence?

Yes	1
No	2
Uncertain	3
May be	4

16.Are you of the view that mentors should be trained and hold and appropriate qualification?

Yes	1
No	2
Uncertain	3
May be	4

17. Do you feel there is a need to review the current mentoring system to uphold its standard?

Yes	1
No	2
Uncertain	3
May be	4

18. According to you what are the **three most** importantskills that a mentor should possess?

Leadership skills	1
Counselling skills	2
Teaching kills	3
Managerial skills	4
Interpersonal skills	5

SECTION C - CLINICAL LEARNING ENVIRONMENT (CLE)

Indicate the extent to which you agree or disagree with each statement below. Circle the number that corresponds to your responses.

Strongly Disagree (SD) - 0 **Slightly Agree (SLA) - 3**

Disagree (D) - 1 **Agree (A)) - 4**

Slightly Disagree (SLD) - 2 **Strongly Agree- (SA) - 5**

		SD	D	SLD	SLA	A	SA
	WARD ORGANISATION						
19	Ward orientation of the student is the responsibility of the ward manager	0	1	2	3	4	5
20	The ward's nursing philosophy is clearly explained to students by the ward manager	0	1	2	3	4	5
21	There is a shared understanding of mentoring in the ward	0	1	2	3	4	5
22	The support of management is important to effective mentoring in the ward	0	1	2	3	4	5
23	The ward is viewed as a social entity, where students' professional growth is enhanced	0	1	2	3	4	5
24	The ward manager ensures there is conducive learning environment	0	1	2	3	4	5
25	The ward is adequately resourced in terms of staff, equipment and supplies	0	1	2	3	4	5
26	The ward has standard operating procedures	0	1	2	3	4	5
27	The ward works in collaboration with all other health professionals	0	1	2	3	4	5
28	The staff shows interest in supervision of students	0	1	2	3	4	5
29	Mentors show interest in patients' care in the ward	0	1	2	3	4	5
30	The ward provides a safe practice environment like use of protective equipment, infection control measures	0	1	2	3	4	5
	COMMUNICATION AND RELATIONSHIP						
31	Mentors are accessible and available when required	0	1	2	3	4	5
32	Mentors communicate regularly with the students	0	1	2	3	4	5
33	Mentors give constructive feedback	0	1	2	3	4	5
34	Mentors provide opportunities for discussion	0	1	2	3	4	5
35	Mentors show interest to support students in their clinical decisions	0	1	2	3	4	5
36	A mentor/ student relationship is trustful	0	1	2	3	4	5
37	A mentor is a good professional role model	0	1	2	3	4	5
38	Mentors have leadership qualities	0	1	2	3	4	5

39	There are no barriers to information flow related to patients care	0	1	2	3	4	5
40	Mentors provide emotional support where appropriate	0	1	2	3	4	5
41	Mentors consider the cultural learning aspect of the students	0	1	2	3	4	5
42	Mentors provide guidance on professional issues	0	1	2	3	4	5
43	Mentors provide counseling for underachievers	0	1	2	3	4	5
	MENTORING						
44	Mentors always create a good learning environment	0	1	2	3	4	5
45	Mentors must clearly communicate responsibilities to students	0	1	2	3	4	5
46	Mentors plan their work according to the learning outcomes and needs of the students	0	1	2	3	4	5
47	Mentors respect student's level and styles of learning	0	1	2	3	4	5
48	Mentors encourage the optimal use of technology to facilitate learning	0	1	2	3	4	5
49	Mentors are supported by highly skilled staff in speciality areas where there is high-tech medicine	0	1	2	3	4	5
50	Mentors always promote evidence based practice	0	1	2	3	4	5
51	Mentors are committed to students' personal growth	0	1	2	3	4	5
52	Mentors help students to reduce the theory practice gap	0	1	2	3	4	5
53	Mentors allow students to practice through simulations						
54	Mentors encourage students to practice under supervision	0	1	2	3	4	5
55	Mentors encourage repeated practice of procedures by students under minimal supervision	0	1	2	3	4	5
56	Mentors allow students to practice independently through reflection once they are confident	0	1	2	3	4	5
57	At the end of placement, mentors ensure students can perform effectively and are proactive	0	1	2	3	4	5
58	Mentors work in collaboration with the clinical team	0	1	2	3	4	5
59	Mentors ensure that students acquire the necessary skills and competencies for their fitness to practice	0	1	2	3	4	5
60	All practical and learning activities of the students are recorded and documented	0	1	2	3	4	5
61	Mentors conduct both practical and theoretical assessment during practice placement of students	0	1	2	3	4	5
62	Clinical assessments of students are based on learning outcomes	0	1	2	3	4	5

63	Mentors assist the students to evaluate their own learning experience	0	1	2	3	4	5
64	Mentors encourage students to engage in critical reflection	0	1	2	3	4	5
	BARRIERS TO EFFECTIVE MENTORING						
65	Increased workload	0	1	2	3	4	5
66	Staff shortage	0	1	2	3	4	5
67	Lack of Knowledge, skill and competence of mentor	0	1	2	3	4	5
68	Inadequate learning resources	0	1	2	3	4	5
69	Ineffective planning regarding practice placement of students	0	1	2	3	4	5
70	Poor management support to learning	0	1	2	3	4	5
71	Mentoring too many students at a time	0	1	2	3	4	5
72	Lack of practice supervision	0	1	2	3	4	5
73	Lack of collaboration between school and practice placement	0	1	2	3	4	5
74	Poor professional relationship	0	1	2	3	4	5

Thank you for the time to share your experiences and your opinions with us. We value your contributions to this research project.

ANNEXURE G: Questionnaire for nurses

Questionnaire number_____

QUESTIONNAIREON MENTORING FOR QUALIFIED NURSES

STUDY TITLE: A conceptual framework for clinical mentoring of student nurses in Mauritius.

Dear Participant,

Please complete all questions on this form which might take approximately 30 - 40minutes. Tick or circle your answer accordingly.

Dhunraj FOOLCHAND

University of South Africa

SECTION A - BACKGROUND INFORMATION

1. Please state your gender -

Male	1
Female	2

2. Your age group -

36 -40 years	1
41- 45 years	2
46-50 years	3
More than 50 years	4

3. Your secondary level of Education

School Certificate/GCE	1
Highest School Certificate/ GCE “A” Level	2

4. Your current position

Ward Manager	1
Charge Nurse	2
Nursing Officer	3

5. Length of service-

15 Years	1
16-20 Years	2
21- 25 Years	3
More than 25 Years	4

6. Professional Qualifications

Diploma in General Nursing	1
Degree in Nursing (BSc/BSN)	2
Master in Nursing (MSc/MSN)	3
PhD Nursing	4

Please specify any other qualifications you hold: ----------

7. Are you currently enrolled in a part time course for your professional growth?

(a) Yes ☐ (b) No ☐

If yes, please specify ----------

8. Your current posting - (a) General ward ☐

Specify which clinical area …….

(b) Specialised Unit ☐

Specify which unit ……..

SECTION A- CURRENT PRACTICE OF MENTORING

Mentoring is the process where a more experienced individual uses his/her greater knowledge, skills,
experience and understanding to support the development of a junior or less experienced individual.

Mentor- refers to the more experienced nurse in the mentoring relationship. The term mentor in this questionnaire refers to qualified experienced nurses who have already completed their top up Diploma programme in General Nursing.

9. Is there a mentoring system in the ward to support students learning?

Yes	1
No	2
Uncertain	3

10. How often were you mentored during your training as a student nurse?

Frequently	1
Occasionally	2
Sometimes	3
Rarely	4

11. Do you consider the current mentoring system to be

Formal Mentoring	1
Informal Mentoring	2
Both formal and informal Mentoring	3
Uncertain	4

12. How often do you mentor students?

Frequently	1
Occasionally	2
Sometimes	3
Rarely	4

13. To what extent does the actual mentoring system answer the learning needs of students' placement?

To a great extent	1
To a little extent	2
Uncertain	3
To a very low extent	4

14. How many seminars or workshops have you ever attended on mentorship during the past three years?

One	1
Two	2
Three	3

More than three	4
Never	5

15. How frequent do Nurse Educators from school visit students during their clinical placements?

Often	1
Occasionally	2
Sometime	3
Rarely	4
Never	5

16. Taking into consideration the various constraints of the clinical learning environment, what would be the ideal ratio of mentor to students'?

1:1	1
1:5	2
1:10	3
1:15	4

17. Are you of the view that all qualified nurses should act as mentors

Yes	1
No	2
Uncertain	3
May be	4

18. Are you of the opinion that mentor should be considered as a separate career pathway?

Yes	1
No	2
Uncertain	3
May be	4

19. Does mentoring help in shaping your professional development and self confidence?

Yes	1
No	2
Uncertain	3
May be	4

20. Do you think mentor as a career pathway can contribute to job satisfaction and staff retention?

Yes	1
No	2
Uncertain	3
May be	4

21. As a mentor would you fail students who are poor performers?

Yes	1
No	2
Uncertain	3
May be	4

22. Are you of the view that mentors should be trained and hold and appropriate qualification?

Yes	1
No	2
Uncertain	3
May be	4

23. Do you feel that there is a need to review the current mentoring system to uphold its standard?

Yes	1
No	2
Uncertain	3
May be	4

B. CLINICAL LEARNING ENVIRONMENT (CLE)

Indicate the extent to which you agree or disagree with each statement below. Circle the number that corresponds to your responses.

Strongly Disagree (SD) - 0 **Slightly Agree (SLA) - 3**

Disagree (D) - 1 **Agree (A) - 4**

Slightly Disagree (SLD) - 2 **Strongly Agree- (SA) - 5**

		SD	D	SLD	SLA	A	SA
	WARD ORGANISATION						
24	Ward orientation of the student is the responsibility of the ward manager	0	1	2	3	4	5
25	The ward's nursing philosophy is clearly explained to students by the ward manager	0	1	2	3	4	5
26	There is a shared understanding of mentoring in the ward	0	1	2	3	4	5
27	The support of management is important to effective mentoring in the ward	0	1	2	3	4	5
28	The ward is viewed as a social entity, where students' professional growth is enhanced	0	1	2	3	4	5
29	The ward manager ensures, there is conducive learning environment	0	1	2	3	4	5
30	The ward is adequately resourced in terms of staff, equipment and supplies	0	1	2	3	4	5
31	The ward has standard operating procedures	0	1	2	3	4	5
32	The ward works in collaboration with all other health professionals	0	1	2	3	4	5
33	The staff shows interest in supervision of students	0	1	2	3	4	5
34	Mentors show interest in patients' care in the ward	0	1	2	3	4	5
35	The ward provides a safe practice environment like use of protective equipment, infection control measures	0	1	2	3	4	5
	COMMUNICATION AND RELATIONSHIP						
36	Mentors are accessible and available when required	0	1	2	3	4	5
37	Mentors communicate regularly with the students	0	1	2	3	4	5
38	Mentors give constructive feedback	0	1	2	3	4	5
39	Mentors provide opportunities for discussion	0	1	2	3	4	5
40	Mentors show interest to support students in their clinical decisions	0	1	2	3	4	5
41	A mentor/ student relationship is trustful	0	1	2	3	4	5
42	A mentor is a good professional role model	0	1	2	3	4	5
43	Mentors have leadership qualities	0	1	2	3	4	5
44	There are no barriers to information flow related to patients care	0	1	2	3	4	5
45	Mentors provide emotional support where appropriate	0	1	2	3	4	5
46	Mentors consider the cultural learning aspect of the students	0	1	2	3	4	5
47	Mentors provide guidance on professional issues	0	1	2	3	4	5
48	Mentors provide counseling for underachievers	0	1	2	3	4	5
	MENTORING						
49	Mentors always create a good learning	0	1	2	3	4	5

	environment						
50	Mentors must clearly communicate responsibilities to students	0	1	2	3	4	5
51	Mentors plan their work according to the learning outcomes and needs of the students	0	1	2	3	4	5
52	Mentors respect student's level and styles of learning	0	1	2	3	4	5
53	Mentors encourage the optimal use of technology to facilitate learning	0	1	2	3	4	5
54	Mentors are supported by highly skilled staff in speciality areas where there is high-tech medicine	0	1	2	3	4	5
	Mentors are allowed special time to mentor students						
55	Mentors always promote evidence based practice	0	1	2	3	4	5
56	Mentors are committed to students' personal growth	0	1	2	3	4	5
57	Mentors help students to reduce the theory practice gap	0	1	2	3	4	5
58	Mentors allow students to practice through simulations						
59	Mentors encourage students to practice under supervision	0	1	2	3	4	5
60	Mentors encourage repeated practice of procedures by students under minimal supervision	0	1	2	3	4	5
61	Mentors allow students to practice independently through reflection once they are confident	0	1	2	3	4	5
62	At the end of placement, mentors ensure students can perform effectively and are proactive	0	1	2	3	4	5
63	Mentors work in collaboration with the clinical team	0	1	2	3	4	5
64	Mentors ensure that students acquire the necessary skills and competencies for their fitness to practice	0	1	2	3	4	5
65	All practical and learning activities of the students are recorded and documented.	0	1	2	3	4	5
66	Mentors conduct both practical and theoretical assessment during practice placement of students	0	1	2	3	4	5
	There is an established framework for clinical assessment						
67	Clinical assessments of students are based on learning outcomes.	0	1	2	3	4	5
68	Mentors assist the students to evaluate their own learning experience	0	1	2	3	4	5
69	Mentors encourage students to engage in critical reflection	0	1	2	3	4	5
	Nursing homes, private clinics and community						

	settings can also serve as practice placements						
	BARRIERS TO EFFECTIVE MENTORING						
70	Increased workload	0	1	2	3	4	5
71	Staff shortage	0	1	2	3	4	5
72	Lack of Knowledge, skills and competencies of mentor	0	1	2	3	4	5
73	Inadequate learning resources	0	1	2	3	4	5
74	Ineffective planning regarding practice placement of students	0	1	2	3	4	5
75	Poor management support to learning	0	1	2	3	4	5
76	Mentoring too many students at a time	0	1	2	3	4	5
77	Lack of practice supervision	0	1	2	3	4	5
78	Lack of collaboration between school and practice placement	0	1	2	3	4	5
79	Poor professional relationship	0	1	2	3	4	5

Thank you for the time to share your experiences and your opinions with us. We value your contributions to this research project.

ANNEXURE H: Letter from statistician

UNIVERSITY OF MAURITIUS
FACULTY OF SCIENCE
Department of Health Sciences

MEMO

Date: 28 June 2016

To whom it may concern

ASSISTANCE IN ANALYSES FOR MR FOOLCHAND

This is to acknowledge that I Dr, Rajesh Jeewon, Senior Lecturer at the Faculty of Science, University of Mauritius will provide the necessary assistance to Mr Foolchand in his project especially on statistical analyses.

UNIVERSITY OF MAURITIUS FACULTY OF SCIENCE

Kind Regards

Dr Rajesh Jeewon PhD
Dept Health Sciences, Faculty of Science, University of Mauritius.
Tel: [230] 4037894.
Fax: [230] 465692

ANNEXURE I: Attendance sheet for stakeholders

ATTENDANCE SHEET

Name	Status	Institution	Signature
Mr. Feroz LALLMOHAMED	Director of Nursing	Ministry of Health and Quality of life	
Mrs. Savita JAGUTPAL	Principal Nurse Educator	Central School of Nursing	
Mr Mike HALKORY	Team Leader/Senior Nurse Lecturer	Lycee Polytechnic Mauritius	
Mr Ram Nowzadick	Ward Manager /President of National Nursing Association	Brown Sequard Hospital	
Mrs Hemawtee PUTTE	Nurse/ Mentor	Victoria Hospital/ Nursing Council	
Mr MallecK TAKUN	Senior Nurse Educator	Central School of Nursing/ Nursing Council	

This is to confirm that the evaluation exercise for the clinical mentoring framework was presented by Mr Dhunraj FOOLCHAND at the Central School of Nursing in the presence of the above panel members.

Mrs. Savita JAGUTPAL
17/6/19
(Principal Nurse Educator)

ANNEXURE J: Interview Transcript

INTERVIEW TRANSCRIPT 008

Interviewer - Mr Dhunraj FOOLCHAND

Interviewee - Mr RAMESH (Participant H)

Date of Interview - 15.09.17

Setting - Surgical Ward (Ward manager's Office at SSRN Hospital)

Starting time - 13:10 Ended - 13:50

(R - Researcher, P - Participant, //... = pause / thinking to reply, [ ] = use of probe by Researcher)

Start of Interview

R. Good morning and thank you for accepting to participate in the study.

P. Thank you.

R. Is this the first time you are participating in a study?

P. No this is the second time am participating in an interview.

R. Anyway for this study I am going to do an interview, so before we start the interview I hope you have read and signed the information/consent form. Your participation is voluntary, you may refuse to answer any questions and that you can withdraw at any time.

P. Yes, I have already gone through and sign it.

R. Before we start, do you have any questions to ask?

P. No

R. Please feel relax and take your time while answering

P. O.K

R. How long have you been working as a qualified nurse and what are the units you have covered so far?

P. I have been working for the past 33 years as a qualified nurse. I have been working in the community surgical, orthopaedic and medical wards, AED unit, ICU and Outpatient Department

R. Can you tell me a little on your professional qualification?

P. I am a charge nurse and I hold a Degree in Nursing since 2004.

THE INTERVIEW

Participant	Dialogue	Non Verbal response
R	**Tell me your experience as a mentor?**	
P	I am going to tell you what I have been observing and doing since my training…..// During my studentship my seniors have been guiding and assisting me and now as an experienced nurse I am sharing my knowledge with the students just as they did	
R	**[In what way you share your knowledge with the students?]**	
P	Usually I do an induction with them so that they know exactly who are the staff with whom they will be working…// and I also show them the various sections of the unit….//normally I advise them that they should complete their placement and make sure they get the maximum exposure from not absenting themselves…//one point which I always share with students is about discipline and they should always	

	show interest in learning and keep up to date with what is happening in the ward …// one thing which I also encourage is that they should observe and know all cases admitted in the ward and also accompany nurses during Doctors' ward round as well…../	
R	**[In addition how do you contribute to student learning?]**	
P	In fact allow me to tell you that the learning aspect is the responsibility of the students...//when I said guiding I mean to say that I usually call them around me whenever I am doing a procedure just to demonstrate how it is done so that they can do it by themselves...//and I always supervise them when they are allowed to do it on their own.	
R	**[So from what I understand you do not do any form of teaching?]**	
P	As such during demonstration I do ask questions depending on the procedure I am doing and quite often the students also interact...../ I think this can not be compared to what is taught at school ..../ as it is very informal. I must also say that as a qualified nurse I am not train in teaching	
R	**[You have said learning is the student's responsibility, what do you do to ensure that this responsibility is met?]**	
P	In fact I always advise the students to keep a notebook to jot down all their observation regarding patients' cases, particularly new diseases ..../ and new line of treatments. At times I invite the students to join in group discussion ..../ this helps them to share knowledge and promotes learning as well..../ very	

	often I also join them when I am free just to motivate them.	
R	**2. What if any, are the constraints that impacts on your role as mentor?**	
P	In fact shortage of nursing staff is a common problem in all the wards where I have been working...../// this shortage impacts on patients' caring that very often I do not have time to coach the students ...../and thus the students are left on their own and just remain like a passive observer...../// I believe this does not benefit the students.	
R	**[You said staff shortage is a common problem, has there been any improvement?]**	
P	As such there has not been big improvement ..../// but instead another problem that has crop up, is that there are too many students in a ward because of regular recruitment of students..../// As a matter of fact these students are often shifted to other units when there is shortage of staff and are used as a pair of hands...../// you can just imagine that it is also difficult for these students to focus on their learning as this does not leave them with enough time..../and I also wonder whether these students do not feel that their practice placement training is being taken for granted.	
R	**[Apart from what you have mentioned, do you think there are any other constraints?]**	
P	Yes personally I think one main constraint is that we do not have qualified mentors..../because I have the impression that management and the school have overlook this aspect since many years...../we must not forget that these students are now being trained at a	

	Diploma level...../and if we want to keep the standards of practice training of students we need trained mentors.	
R	**[You have said "standards of practice training"; how can this be maintained?]**	
P	I must say there is no uniformity the way the students are being supported in the ward..../ that is all nurses coach students in their own way and in a different manner.../ I believe that if there is a clear policy regarding the practice placement of students and mentoring, standards can be maintained.	
R	**3. Describe how mentoring contribute to the professional growth of students in the preparation for fitness to practice?**	
P	I strongly believe that the clinical placement of students plays an important role in shaping the professional development of students..../ but the students have to commit themselves to learning if they want to grow professionally.../ and without proper mentoring the student will not be able to progress further.	
R	**[Could you explain how they progress?]**	
P	In fact the students are encouraged to make the most of their clinical placement...../ they are rotated to various wards so that they cover all the units and specialities..../ during this period they are exposed to real practice situations which is different from what they have learned at school ...../ and all through their placement they are guided, supervised and coached by experienced nurses../ thus they gain experience in different fields and I think this prepares them for their future role as a qualified nurse.	

R	**[But can you tell me how you ensure that they are fit for practice?]**	
P	In fact during the three years placement the students have to enter all the procedures they have been exposed and performed in a log book provided by the School...../// this log book must be signed by nurses who have been coaching them...../// however as a coach I only observe and interact with them ..../// but personally I do not think this log book ensures that the student is equipped with the necessary skills and competencies	
R	**[Why do you think so?]**	
P	I am saying this because these students are not assesed by nurses during their placement..../instead they are assessed for their practice by the Educators during the final examination ...../// it is important to note that these Educators have not been by the side of the students in the practice ...../// and neither there is monitoring from school regarding the theory practice gap	
R	**4. What should a conducive clinical learning environment consist of with regard to mentoring?**	
P	I really believe that it will be difficult to have a perfect clinical learning environment..../// but at least the basic requirements such as adequate staffing,clean and uncrowded ward , necessary equipments, materials and apparatuses must be made available..../// and I also think it is very important that each and every nursing staff work towards developing a learning culture within the unit	
R	**[Are there other factors that are necessary for a**	

	conducive clinical learning environment?]	
P	Yeah ...../// I think for learning to take place in clinical settings it would be better to have trained mentors posted in all wards..../// as this will ensure that the learning needs of the students are met..../on the other hand the students will be continuously monitored and assessed. ..../// apart from this all the nurses must update their knowledge ..../and lastly the ward manager must gives his full support to the mentors and students for effective mentoring.	
R	**5. According to you what qualities should a good mentor have?**	
P	A mentor must have the qualities of a good nurse the fact he is also a trained nurse..../// that is one who has patience, is empathetic , compassion and shows interest in patients caring and always practice according to standard...../// but I think as a mentor he must be a continuous learner and up date his knowledge , he must be friendly,trusful, and always listen and give feedback to students.../// that is he must value students and keeps a good relationship with them...../this will create confidence and muual respect. But the most important qualities that the mentor must possess are teaching and assessing skills.	
R	**6. What can be done to improve mentoring in the clinical environment?**	
P	If we really want to improve mentoring in the clinical environment..../// there must be a firm commitment from policy holders and support of top management...../// it will be important to listen to the Educators, the nurses who support students, the students and the hospital	

	management to know what are the existing shortcomings.	
R	**[There are shortcomings which everyone agrees, but how this can be improved?]**	
P	I think there must be agreed principles from all those involved in the support of students' placements...../it will be better to have qualified and trained mentors who will only be responsible for students during their placement.../ that is mentors who can teach, supervise and assessed students.../but also understand course programme..../these mentors must work in close collaboration with the school.	
R	**[Do you have anything to add?]**	
P	I have nothing to add, but I think if there will be trained and qualified mentors and a well equipped ward , the whole problem of mentoring will be solved.	

Thank for your participation.

ANNEXURE K: Language editing certificate

Between the lines editing

Leatitia Romero
Professional Copy-Editor, Translator and Proofreader
(BA HONS)

Cell: 083 236 4536
leatitiaromero@gmail.com
www.betweenthelineseditting.co.za

6 December 2019

To whom it may concern:

I hereby confirm that I have edited the thesis entitled: A CLINICAL MENTORING FRAMEWORK FOR STUDENT NURSES IN MAURITIUS". Any amendments introduced by the author hereafter are not covered by this confirmation. The author ultimately decided whether to accept or decline any recommendations made by the editor, and it remains the author's responsibility at all times to confirm the accuracy and originality of the completed work.

Leatitia Romero

(Electronically sent – no signature)

Affiliations

PEG: Professional Editors Group (ROM001)
EASA: English Academy of South Africa
SATI: South African Translators' Institute (1003002)
SfEP: Society for Editors and Proofreaders (15687)
REASA: Research Ethics Committee Association of Southern Africa (104)

ANNEXURE L: Turnitin Report

Log in to Turnitin

Email address

36763365@MYLIFE.UNISA.AC.ZA

NOW VIEWING:

- HOME > CHS M&D STUDENTS 2019: MARITZ, JEANETTE

About this page

This is your student homepage. The homepage shows the classes you are enrolled in. To enroll in a new class, click the enroll in a class button. Click a class name to open your class homepage for the class. From your homepage, you can submit a paper. For more information on how to submit, please see our help page.

University of South Africa: CHS

Class ID	Class name	Instructor
20710315	CHS M&D Students 2019 (Maritz, Jeanette)	Jeanette Maritz
10199984	D-students (closed)	Jeanette Maritz

Submit: Single File Upload

Congratulations - your submission is complete! This is your digital receipt. You can print a copy of this receipt from within the Document Viewer.

Author:
Dan Foolchand

Assignment title:
Complete dissertation/thesis submission for examination

Submission title:
Complete thesis

File name:
TURNITIN DRAFT.docx

File size:
665.92K

Page count:
139

Word count:
37332

Character count:
208026

Submission date:
10-Dec-2019 01:59PM (UTC+0200)

Submission ID:
1231452549

« Page 1 »

Return to assignment list

Complete dissertation/thesis submission for examination Due30-Jan-202011:59PM9%